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REHABILITATION LITERATURE

National Society for
Crippled Children and Adults

Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of cooperative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

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Books for review and correspondence relating to feature articles and other editorial matters should be addressed to the editor. He will welcome your suggestions.

REHABILITATION LITERATURE

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A Comment on

The Adaptability of Disabled Workers

"THERE IS A MOST ANCIENT and overworked cliché in commerce and industry, the one about putting square pegs in square holes and round pegs in round holes.

"It isn't bad as clichés go. But this apt phrase can have an unfortunate influence on the placement of workers. It precludes unusual pegs such as our disabled workers. It implies that all pegs are neatly and conveniently pre-shaped and that all we need to do is determine the shape and slip the peg into the proper hole. At once, the peg is adjusted and we can rest assured that maximum use is being made of it.

"We readily forget one thing. Putting a square peg in a square hole is the best way of denying it any room for movement or expansion.

"There was a time, not too long ago, when we looked on the job as a fixed, inflexible commodity. In a surplus labor market we sought men to meet the rigid demands of the job. There were plenty of job applicants. We could pick whoever suited.

"In periods of critical manpower shortages, a new theory was developed. We learned that the job requirements were not so rigid after all. Job simplifications and job breakdowns were possible. Surprisingly, they not only allowed a more flexible recruitment policy but they increased efficiency and cut costs. In the period of scarce manpower during World War II this job simplication technique especially benefitted the disabled worker. He was more readily absorbed into industry. There was more that he could do.

"Now we come into a new era. The recognition that the man too, the worker, is a changeable, changing commodity in industry. In medical and rehabilitation circles we have been doing just that for years. Artificial legs, crutches, braces, wheel chairs, miracle drugs, new techniques of surgery, have changed men just as industry has changed machines.

"The amazing thing about this research is the group at Abilities Inc., the supervisors and workers. Aside from being physically disabled, most of them had no prior industrial experience. If they had any, it was rarely comparable to their present job demands.

"Fortunately, we have discovered that there is no substitute for the desire and will to work. Man is a tremendously adaptable creature. With proper guidance and encouragement, he has an almost unlimited capacity to undertake and succeed at work entirely foreign to his background. He can derive great satisfaction from the experience. . . .

"It is not as simple as square pegs in round holes or round pegs in square holes. There is more to it than just that. What we need is not only a good system for filling jobs and getting men started in an organization. We must not stop there. It takes a lot of study to find a peg's true dimensions, for human pegs, like jobs, are many sided, and just about the time we think we have them accurately gauged, another side turns up. We must recognize the changing characteristics in our men as well as our machines and the need to relate them to one another."
—*From Conclusion, p. 24-26, to* A Study of the Adaptability of Disabled Workers, *by William J. Campbell, M.A., Raymond R. Leizer, B.S., and Harold E. Yuker, Ph.D. 1958. Human Resources Corporation, Division of Abilities Inc., Albertson, Long Island, N. Y. $1.00.*

REHABILITATION LITERATURE

Article of the Month

More Effective Rehabilitation

Through Rehabilitation Center and State Vocational Rehabilitation Agency Cooperation

Willis C. Gorthy
and
Nathan M. Slater

Five years have elapsed since the passage of the 1954 Amendment to the Rehabilitation Act gave a new impetus to rehabilitation in the United States. During this period rehabilitation center capacity has been increased several times, the colleges and universities have stepped up the training of rehabilitation specialists, greater effort has gone into rehabilitation research, and federal and state governments as well as voluntary rehabilitation agencies have more than doubled the rate of expenditure for services. In the midst of all this activity only limited progress has been made toward developing closer relationships between the rehabilitation center and the state vocational rehabilitation agency.

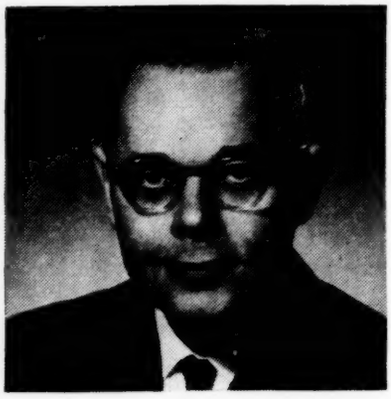
These two organizations are vital cogs in the machinery of rehabilitation serving the severely disabled. Improvement and extension of services to this group of clients hinges, on the one hand, upon the establishment in the center of the kind of services needed by state agency clients and, on the other, upon an appreciation by the state agency of the unique position of the center in providing coordinated services available in no other facility. The centers have the capacity and specialized personnel to deal with the problems of severe disability. The state agencies have the case-finding apparatus, vocational counseling skills, and intimate knowledge of vocational opportunities in the community as well as the ability to finance the necessary programs. It is clearly to the advantage of both organizations to learn how to work together with greater effectiveness.

An effective relationship has been developed between the Institute for the Crippled and Disabled (ICD) and the state vocational rehabilitation agencies, especially the New York State Division of Vocational Rehabilitation (DVR). The manner in which it was achieved

About the Authors . . .

Mr. Gorthy has been the Director of the Institute for the Crippled and Disabled since 1953 and prior to that was its Associate Director for four years. Especially interested in the improvement of rehabilitation center management, he is active in national and international rehabilitation organizations. His activities include: President Elect of the Conference of Rehabilitation Centers and Facilities; Board of Directors, Association of Sheltered Workshops and Homebound Programs; Executive Committee of the President's Committee on Employment of the Physically Handicapped; Advisory Committee on Sheltered Workshops of the U.S. Department of Labor; Planning Committee for the Eighth World Congress of the International Society for the Welfare of Cripples; Rehabilitation Policy Committee of the National Rehabilitation Association. Mr. Gorthy has served as consultant on rehabilitation center development for a number of United States communities and recently returned from an assignment to Turkey for the United Nations.

Mr. Slater is an Associate Counselor with the New York State Division of Vocational Rehabilitation in New York City. Employed by DVR since 1944, he has had numerous assignments in such areas as in-service training, studies of the nature of the caseload, and liaison with the Workmen's Compensation Board to extend the use of DVR services to the industrially injured. Prior to assuming his present position, Mr. Slater was supervisor of the Industrial Accident Unit in the New York City office of DVR and was instrumental in creating widespread use of vocational rehabilitation services by casualty insurance carriers for industrial accident cases. In 1955 and 1956 he was the Project Director of the Training Center and Workshop established by the Association for the Help of Retarded Children in New York City.



Left: Willis C. Gorthy

Right: Nathan M. Slater

is described by the authors. It is hoped that this experience in developing a joint effort of ever-increasing effectiveness may point out ways for other rehabilitation centers and state agencies to resolve some of the problems facing them.

History of ICD-DVR Relationship

An effective working agreement between two independent agencies requires a willingness to understand each other's peculiarities and to make an honest effort to compromise differences in operating policies. Not more than a handful of DVR-sponsored clients had been served by ICD from the date of its founding in 1917 to 1951. The main reason for this situation was the conflict in operating policies from which neither party was willing to deviate to meet on common ground. Briefly stated, ICD was dedicated to a policy that required complete freedom of action in evaluating the clients referred to it. It made a ritual of a routine that permitted no deviation. DVR felt that ICD failed to state clearly its specific recommendations for persons referred from DVR prior to instituting services. This caused DVR to lack control in the supervision of its cases. DVR maintained that its legal responsibility was to counsel and guide the vocationally handicapped client toward the choice and pursuit of a suitable vocational objective. Therefore, DVR repeatedly cautioned that persons referred by it were to be given only specifically authorized services at ICD.

In 1950 an attempt was made to negotiate a joint agreement between the two agencies. After months of study and deliberation, a formal document outlining the services, rates, and responsibilities resulted. This agreement included a statement of DVR policy concerning its legal responsibility that would require ICD to confine its services to those prescribed by DVR. Its importance for the DVR was seen to lie in the specific services available in: (1) physical restoration, (2) personal adjustment training, and (3) vocational preparation.

Very early in the working relationship, DVR counselors visited ICD and observed as well as discussed its operations and procedures. Shortly after inception of the program, a survey of DVR experience indicated no evidence of any cross-counseling or usurpation of DVR functions. However, it became obvious that the divergent operating policies of the two agencies would seriously limit the effectiveness of the joint program, specifically with respect to unavoidable delays in providing services to clients due to the step-by-step authorization of the component parts of the evaluation program.

In recognition of the need to improve the working relationship and the extension of services needed by clients, serious and frank discussions of the shortcomings of the existing agreement were held. From them came a significant change in the operating policy of both agencies. It was agreed that DVR was legally responsible for authorizing services for its clients and that prior authorization was required before the start of any program. DVR accepted the ICD policy of making a comprehensive evaluation of severely disabled clients to determine their suitability for a rehabilitation program. The need to give ICD flexibility in the scope, timing, and scheduling of its evaluation program was recognized by DVR.

The "Package" Evaluation Plan

With this understanding reached, a method was devised to assure ICD flexibility while the legal responsibility of the DVR counselor was observed. This device was the creation of an evaluation service for DVR clients known as the Combined Evaluation Service. It became known as CES or the "package evaluation." The CES was offered by ICD at a fixed rate for all types of clients. (Not included were the emotionally ill and the mentally handicapped where the psychiatric condition was the dominant and significant disability, since these disability groups were not served regularly by ICD at that time.) The CES included: a

rehabilitation medical examination; medical consultations as required; a social intake study; and psychological tests. These diagnostic examinations and tests were followed by a three-week period of full-time vocational evaluation using the job sample technic. The CES was definitely not a substitute for Personal Adjustment Training, nor was it a crutch to take the place of counseling by the vocational rehabilitation counselor. It was to be used in cases of severe disability and when the vocational plan was not clear without further evaluation. Care was to be exercised to prevent duplicating services already rendered within the operation of the DVR program. Further, it was stressed that ICD should avoid the guiding of clients into one of its specific vocational areas when some other program might be more feasible from a placement standpoint. However, there was recognition that DVR clients often needed "on-the-spot" vocational counseling that could best be provided by the ICD staff counselors because of their immediate availability. It was agreed that, both during evaluation and other service programs, the ultimate vocational objective would be developed by the client and the DVR counselor and that the site of training, if any, would be determined by the referring agency.

The DVR counselor in each case was expected to visit his client during the evaluation period and to participate in the ICD staff conference held at the close of the client's vocational evaluation period. This evaluation conference had the responsibility of developing recommendations for planning rehabilitation for clients who demonstrated any vocational capability. The conference might recommend any of the following: (1) a vocational training program at ICD in one of its trade classes or in the sheltered workshop; (2) vocational training in a private trade school; (3) direct placement; (4) on-the-job training; or (5) no rehabilitation service because of infeasibility or the client's lack of interest.

Clients who could benefit from rehabilitation services but for whom DVR service was considered infeasible by the DVR counselor because of limited vocational potential would be considered for admission as ICD clients in a more limited program. A number of these clients have been admitted to ICD for prevocational programs involving physical therapy, occupational therapy, psychotherapy, and academic help. If sufficient improvement was shown to warrant consideration for a vocational program, DVR was requested to accept the client under its sponsorship.

The Modified "Package" Evaluation Plan

A single fee was in effect during the five-year period of 1951 to 1955. It became evident that a single rate for evaluation was inequitable because of the great differences in the evaluation services required for various types of disabilities. Based on an analysis of ICD costs, a modification of the single-fee package was developed to provide three rates that were generally proportional to the scope of the evaluation effort required. DVR clients were grouped for services as follows:

- CES #1 Clients who appeared to present uncomplicated orthopedic rehabilitation problems, such as in amputations, fractures, or poliomyelitis.
- CES #2 DVR clients normally included under CES #1 but presenting extensive emotional and social problems.
- CES #3 DVR clients grouped generally as having disabilities resulting from brain damage such as in cerebral palsy, strokes, and head injuries.

The evaluation process included an intake interview, the rehabilitation medical examination, psychological tests, and the three-week vocational evaluation period, and in CES #2 and CES #3 additional diagnostic tests and examinations. This arrangement was in effect during 1956 and 1957. Experience with this approach showed a number of shortcomings. It was found that types of disabilities could not be categorized as to the extent of evaluation needs. This resulted in evaluation services being provided routinely for CES #2 and CES #3 clients when there sometimes was no need for the full range of services. In other instances, a client classified for CES #1 or CES #2 might require more extensive services than those stipulated. The major shortcoming of this approach was a forced rigidity in the evaluation system that prevented the ICD staff and the DVR counselor from arranging the scope of evaluation required to fit more precisely the needs of the client.

Flexible Evaluation Plan

The seven years of experience resulted in further study of an evaluation service that would permit flexibility in selection of services so that the client could be properly evaluated and administration could be handled by both ICD and DVR without undue complication. A plan was agreed to that is known as the Diagnostic Vocational Evaluation (DVE) because of the emphasis given by the DVR program on a vocational objective in the evaluation process. This plan has been in effect since the latter part of 1957. The DVE is made up of three phases as follows:

- Phase I: Intake screening for all clients including rehabilitation medical examinations; social intake study; and psychological

review of available materials or selected tests if required.

Phase II: Specific diagnostic tests and examinations recommended as the result of Phase I intake screening and/or requested by DVR counselor prior to admission, selected from the available services as follows:
Consultations in: internal medicine; orthopedics: neurology; ophthalmology.
Speech and hearing evaluation.
Extensive social case study.
Brain-damage evaluation (visual-motor psychological).
Psychological test battery including such projective and personality tests as are determined to be required by the ICD staff psychologist or psychiatrist.
Psychiatric review of available psychological, psychiatric, and social study reports, or psychiatric consultation.

Phase III: Three-week, full-time vocational evaluation for DVR clients found acceptable as a result of Phase I and Phase II services.

A fixed fee is charged for Phase I and Phase III services. A standard schedule of fees covers additional services under Phase II. Each client is thus provided a range of services permitting the full evaluation of his rehabilitation problem.

Role of the DVR Counselor

The DVR counselor's initial responsibilities are: 1. Proper selection of the client for referral to the rehabilitation center and preparation of the client to accept center services. Of primary consideration in the selection process is a possible rejection of the center by the client, solely because he refuses to identify himself with the seriously disabled. 2. Referral of information and advice to the rehabilitation center including the transmittal of all available background and medical information, a statement of specific services authorized, and statement of any maintenance allowances authorized and method of payment.

During the evaluation period the DVR counselor functions as a member of the team. Among his responsibilities are: 1. Contact with the client and with center staff members to assist in clarifying any problems. 2. Authorization of any additional service found to be necessary during the evaluation period. 3. Participation in the professional staff case conference at the center to develop the rehabilitation plan. 4. Authorization of the accepted rehabilitation program to be carried out either at the center or elsewhere.

Increased Use of Center Services by DVR

Table 1 shows the increase in use of center evaluation services over the eight-year period resulting from the cooperative efforts of the two agencies. In 1958 the total referrals from DVR amounted to 37 percent of all those served by ICD, exclusive of its prosthetic and orthopedic appliance service. In 1958, DVR referrals amounted to 72 per cent of all those referred to ICD for vocational programs. In addition to those referred for total evaluation, some DVR clients are directly accepted for Personal Adjustment Training (PAT), which consists of a period for developing suitable habits, attitudes, and physical tolerance in a vocational setting, or direct admission to trade training classes can also be arranged. Such direct acceptances are of clients on whom sufficient medical, psychological, and vocational information is available to justify the omission of the evaluation program.

TABLE 1.—*Total DVR Referrals to ICD for All Purposes from 1951 Through 1958*

	1951	1952	1953	1954	1955	1956	1957	1958
Annual DVR Referrals..	*7*	*167*	*200*	*249*	*369*	*376*	*380*	*416*
Evaluation Services Completed (Regular Program).....	*5*	*63*	*94*	*131*	*161*	*179*	*171*	*211*
PAT.....	5	51	39	33	41	25	30	5
CES.....	—	12	55	98	120	—	—	—
CES #1.....	—	—	—	—	—	54	41	—
CES #2.....	—	—	—	—	—	56	48	—
CES #3.....	—	—	—	—	—	44	23	—
DVE.....	—	—	—	—	—	—	29	206
Evaluation Services Partially Completed..	—	*91*	*94*	*104*	*145*	*128*	*136*	*97*
Rejected by ICD admissions Committee	—	20	24	30	40	47	45	46
Evaluation program interrupted.....	—	71	70	74	105	81	91	51
Evaluation Services Completed (Cerebral Palsy Research Project).....	—	—	—	—	*47*	*56*	*50*	*65*
Direct Admissions to Training Classes.....	*2*	*7*	*5*	*7*	*8*	*3*	*2*	*3*
Admissions for Other Services Medical treatment or psychological services.....	—	*6*	*7*	*7*	*8*	*10*	*21*	*40*

DVR—Division of Vocational Rehabilitation ICD—Institute for the Crippled and Disabled PAT—Personal Adjustment Training CES—Combined Evaluation Service DVE—Diagnostic Vocational Evaluation

The age and sex of DVR clients referred to ICD for the regular and Cerebral Palsy Research Project evaluation programs during the last seven years are given in Table 2. The disabilities represented in the referrals for the regular evaluation service are given

TABLE 2.—*Selected Characteristics of Clients Referred for Evaluation—1952 Through 1958*

	1952	1953	1954	1955	1956	1957	1958
Regular Evaluation Program							
Age range, years	17-67	16-61	16-67	16-66	15-62	17-65	16-59
Average age, years	37.5	35.0	36.5	37.9	40.1	41.1	43.0
Percentage of males	72%	80%	77%	79%	83%	84%	87%
Percentage of females	28%	20%	23%	21%	17%	16%	13%
Cerebral Palsy Research Project							
Age range, years				15-35	15-36	15-38	15-37
Average age, years				19.8	21.7	22.8	18.4
Percentage of males				75%	73%	63%	60%
Percentage of females				25%	27%	37%	40%

in Table 3. They do not include the cerebral palsied clients who are referred to the research project sponsored by the Office of Vocational Rehabilitation to develop improved technics of evaluating the vocational potential of the cerebral palsied adult. The results to date in the latter program are shown in Table 4.

ICD includes in its rehabilitation services a vocational school for training in a trade that gives instruction in a number of trades and commercial subjects and an industrial workshop where training in industrial sewing machine operation, electronic assembly, and light manufacturing is provided. Table 5 shows the vocational recommendations resulting from the evaluation of DVR clients during the eight-year period. Table 6 shows the number of DVR clients recommended for a continuing program at ICD and for which DVR approval was received.

Experimental Programs for Special Disability Groups

The closer working relationship that developed steadily between the ICD staff and DVR counselors

TABLE 3.—*Disabilities Represented in DVR Clients in Regular Evaluation and Training Cases*

Disability Group	1952	1953	1954	1955	1956	1957	1958
Amputations—upper and lower extremity	6	5	13	8	7	19	25
Brain damage—cerebral palsy, hemiplegia, accidents, and others	29	32	38	44	35	27	32
Diseases of bones, joints, and muscles—arthritis, back injury, fractures, and dislocations	19	31	47	77	89	60	79
Lower motor neuron disease—poliomyelitis	3	5	6	6	6	7	8
Spinal cord damage—paraplegia, multiple sclerosis	3	4	12	9	5	7	8
Pulmonary tuberculosis or cardiac, hearing, and visual weakness	7	12	16	18	30	46	49
Psychiatric conditions	—	—	—	—	—	2	3
Miscellaneous	3	10	6	7	10	5	10
Totals	70	99	138	169	182	173	214

TABLE 4.—*Vocational Evaluation Recommendations, Cerebral Palsy Research Project—1955 Through 1958*

	1955	1956	1957	1958
Total DVR Clients Admitted During Year	*47*	*61*	*50*	*56*
Vocational Recommendations				
Trade training at ICD	8	6	7	12
Industrial workshop training at ICD	5	3	1	5
Direct placement	11	12	7	5
Training in private trade school	7	14	8	11
Placement in outside workshop	10	15	16	12
Vocational rehabilitation not feasible for medical, psychological, or vocational reasons	0	1	0	0
Not interested	3	0	4	1
Returned to high school	3	10	7	10

has led to the development of a number of new programs by the two agencies. One of the most rewarding has been the Cerebral Palsy Research Project. The United Cerebral Palsy organizations of New York and Queens, the New York State Employment Service, the New York State Division of Vocational Rehabilitation, and the ICD are all participants. The improved methods developed have already been approved by OVR as the prototype for this kind of service to be extended to other communities.

There have been a number of other cooperative programs for DVR clients served by ICD. Each summer a special evaluation period for disabled high school students provides recommendations for the guidance of school authorities and DVR counselors useful during the final years of high school and the period following. Other cooperative ventures have been a pilot program for the evaluation of adult epileptics with uncontrolled seizures and a program with the Rheumatism and Arthritis Foundation of New York to demonstrate the effectiveness of rehabilitation center services in returning the arthritic patient to full-time employment. Effort is coordinated with the New York State Insurance Fund and the DVR to assure continuity of rehabilitation services for industrial

TABLE 5.—*Vocational Evaluation Recommendations, Regular Evaluation Program—1951 Through 1958*

	1951	1952	1953	1954	1955	1956	1957	1958
Total DVR Clients Admitted During Year	*5*	*63*	*94*	*131*	*161*	*179*	*171*	*211*
Vocational Recommendations								
Trade training at ICD	1	21	53	63	84	66	95	98
Industrial workshop training at ICD	2	13	24	20	32	28	32	42
Direct placement	1	10	4	18	16	28	11	18
Training in private trade school	—	2	2	5	10	14	5	10
Vocational rehabilitation not feasible for medical, psychological, or vocational reasons	1	12	6	15	10	26	20	31
Not interested	—	5	5	10	9	17	8	12

TABLE 6.—*DVR Clients Returned to ICD for Rehabilitation Services After Evaluation—1951 Through 1958*

	1951	1952	1953	1954	1955	1956	1957	1958
From Regular Evaluation Program to:								
Trade training classes	—	16	41	54	71	48	82	81
Industrial workshop training	1	12	20	15	22	20	24	36
Placement service	—	—	—	—	—	10	6	5
Approved also for concomitant mental hygiene therapy	—	—	—	—	—	(12)	(14)	(12)
Totals	1	28	61	69	93	78	112	122
Totals as Percent of Those Recommended	25%	82%	79%	83%	80%	72%	83%	84%
From Cerebral Palsy Research Project Evaluation to:								
Trade training classes					8	5	6	9
Industrial workshop					5	3	2	3
Totals					13	8	8	12
Totals as Percent of Those Recommended					100%	89%	100%	71%

accident patients as the emphasis in the rehabilitation program changes from physical medicine to vocational training. Special placement services are provided by the ICD full-time placement staff to assist DVR counselors in difficult placement cases. The ICD Social Adjustment Service provides supportive mental hygiene services for selected clients who require such services concomitant with vocational training. Most recently, a pilot project (using an expanded DVE program) has been started for a limited number of DVR clients with mental disabilities to determine if they can be served effectively in a rehabilitation center setting that primarily serves the physically disabled.

Summary

Close cooperation between a voluntary comprehensive rehabilitation center and a state vocational rehabilitation agency is demonstrated by the manner in which since 1951 the Institute for the Crippled and Disabled (ICD) and the New York State Division of Vocational Rehabilitation (DVR) have developed increasingly effective services for DVR referrals. In 1958, DVR referrals represented 37 percent of the total ICD caseload and 72 percent of its referrals for vocational programs. A relationship has been developed that gives the center flexibility in its evaluation process and recognizes the legal responsibility of DVR to its clients. A package evaluation plan evolved that permits the provision of a range of services by the center that can meet the precise needs of each client. The DVR counselor fills a key role in the evaluation process and functions as a member of the center's evaluation team. As the staffs of the two agencies learned to work together, new approaches to difficult problems represented in DVR clients are being resolved by joint staff effort.

The Mentally Retarded in Society

By Stanley Powell Davies, Ph.D.
with the collaboration of
Katherine G. Ecob, A.M.

Published by Columbia University Press, 2960 Broadway, New York 27, N.Y. 1959. 248 p. tabs. $5.50.

Reviewed by Christine P. Ingram, Ed.D.

About the Authors...

Dr. Davies is Chairman of the Functional Planning Board of the Community Council of Greater New York and formerly was General Director of the Community Service Society, New York City. He is a board member of the New York State Society for Mental Health and the chairman of its Field Study Committee.

Miss Ecob, well-known for her contributions in the field of mental retardation, has served as psychologist with the former New York State Commission on Mental Defectives and as Executive Secretary of the New York State Committee on Mental Hygiene.

About the Reviewer...

Dr. Ingram has been professor of Education and Psychology at Illinois State Normal University, Normal, Ill., since 1949. She is author of the textbook "Education of the Slow-Learning Child" and of many articles. Widely traveled, she was consultant to the Turkish Ministry of Education, Ankara, in 1953-54 and in 1956-57 was Visiting Professor and Consultant in Psychological Services at the American University, Cairo, Egypt.

The growing number of publications in the field of mental retardation, all bearing dates in the '50's, is heartening, as it indicates an awakening concern in a field that for some time has received scant attention from psychologists, psychiatrists, and sociologists. The majority of the authors have treated the areas of etiology, psychology, parent-counseling, the retarded child in the home, programs for education, rehabilitation services, and research. This text, a second revision of an early treatise, is unique in presenting a historical setting for today's problems in the field of mental retardation and for giving emphasis to the "socializing process" as the goal for the retarded individual in our culture. The title "The Mentally Retarded in Society" reflects the changing concepts within the field. The earlier edition published in 1930 was entitled "Social Control of the Mentally Deficient." Today's title suggests a more hopeful approach, *i.e.,* individuals are considered worthy of acceptance by society and of appropriate services to bring about their optimum development.

The author, Stanley Powell Davies, a sociologist closely associated with the early medical pioneers in American institutional developments, Walter Fernald of Waverly, George Wallace of Wrentham, Charles Bernstein of Rome, and Sherman Little of Letchworth Village, perceived clearly the nature of the problems that confronted these workers and their undaunted efforts to investigate, to hypothesize, and to try out practices pointing toward solutions. Both Davies and Katherine Ecob, who collaborated with him in this edition, have long been active in promoting the social welfare and mental health of the retarded and can take a long-range view. Such an approach is invaluable as an aid to better understanding of progress or lack of progress over the years and of current movements and their direction.

Although in the current edition the material is presented in two parts (Part One, Historical Background, and Part Two, Modern

Programs: Rehabilitation), one is struck with the similarity to the 1930 chapter headings in both title and sequence. The main emphasis is on developments after the turn of the 20th century.

In this edition none of the historical recounting of developments that had major influence on the concepts, theories, and evolution of practices up to 1930 is lost. The careful documentation of facts and opinion is reported in an interesting, vital, and at times dramatic sequence. It is in the earlier chapters of historical background that Davies is at his best. He has recounted the beginnings of the scientific approach in the early 19th century with Itard's teaching of the savage of Aveyron followed by Edouard Seguin's development of the physiological method of sensorimotor training. He described the training programs of the early American institutions for the feebleminded, both public and private, motivated by Seguin with the hope of the individual's restoration and return to the community. He recounts the "invention" of the Binet-Simon intelligence test and its American adaptation, initiated by Dr. Henry Goddard at the Vineland Training School and resulting in intelligence test surveys in institutions and public schools. From these surveys came the correlation of mental age and intelligence levels with the degrees of dependency in the institution, with the delinquent and criminal behavior of prison and reformatory inmates, and with the academic failure of the overage retarded school child. Added to these negative findings were the eugenic inferences of heredity and fecundity as the chief cause, derived from the sociological studies of the Jukes and the Kallikaks. Davies also included the comparable findings of the British Royal Commission and Tredgold's statements, which added their weight to the developing concepts. The movement to arouse public support for sterilization and segregation as necessary preventive social measures was well under way by 1915.

Then came the decade 1920-1930, of sober reexamination of mental age and intelligence levels in the American population, the results of the army tests, the successes of institutional parolees and of special class graduates from the public school, and the discovery of factors other than intellectual deficit causing delinquency and crime. As a result the concept of differentiation within the group was formulated, of the feebleminded requiring care and supervision, of the defective delinquent in need of life segregation and training, and of the intellectually subnormal with potentiality for social and occupational adequacy. On the premise of this concept the recommended solution in 1930 lay in the state institution with its emanating services to the community and in the extension of special education programs in the public school.

In Part Two, "Modern Programs: Rehabilitation," programs developed from 1900 on are discussed, the state-operated clinics for diagnosis, extrainstitutional services of colonies, parole, family care, home teaching, and community supervision headed up in a state commission or welfare agency. Briefly stated are more recent federal programs of medical research, of clinical diagnostic services, and of educational research projects stemming from the Department of Health, Education, and Welfare. The work of the National Association for Retarded Children, parent-sponsored and organized in 1950, is cited. This association has fostered public interest and set up privately supported day classes and sheltered workshops.

A full chapter is given to "The Challenge to the Schools." Davies regards the extension of special classes that provide early discovery, parent education, and differentiated curriculum as the chief means of meeting the needs of the mentally retarded. The studies and services of Emily Burr's Vocational Adjustment Bureau in New York City from 1919 to 1946 introduce a chapter on "Vocational Training and Employment." There is descriptive material on current programs of the Office of Vocational Rehabilitation and those of the United States Employment Service carried out by state agencies in cooperation with public schools and institutions.

In the final chapter "The Mentally Retarded in the Social Order," there is a general statement of the mentally retarded's potentialities for "usefulness" and "happiness" in a society where the diversity and division of labor have needs and rewards. After this statement is an outline of the essential features of a comprehensive state and community program covering a long list of services. In the earlier chapters, the evolution and function of many of these services were discussed, but others have been given only brief mention. While the early chapters dovetail for the reader the work and research of psychologist, physician, sociologist, and eugenist in formulating concepts, hypotheses, and programs, the reviewer misses a similar treatment of interpretation for the present movement with its extension of services.

Would it have strengthened the author's purpose to summarize the developments in the past 10 years that have brought this unprecedented focus on research in the causes and nature of mental retardation, on restudy of present services, and on formulation and evaluation of new services? There is need to emphasize that medical, biological, and psychological research, revealing wide diversity in syndromes, etiology, behavior, and learning problems (pages 85-89), has significant bearing on programs. For example, there is the current recognition of pseudofeeblemindedness and the several factors that may cause it, chief among them the impact of emotional interference on intellectual functioning. The significance of these findings for the redefinition, diagnosis, and treatment of the "defective delinquent" (pages 71-80) cannot be overlooked. There is need to make clear that the nature and implementation of many of the services listed (pages

228-231) are in process of study and experimentation, supported by government and private agency grants. Research and coordination on the part of many specialists and agencies over a period of years are needed so that scientifically derived concepts and practices may furnish a sounder basis for moving toward the future.

Mental retardation is relative to the culture in which the individual lives. As our society becomes more complex with increased demands and pressures, adjustment presents added problems. In non-European countries where large rural populations without schooling are engaged in agriculture and handcrafts, there is no comparable problem of mental retardation. Egypt, for example, is such a country in the process of extending health, education, and welfare services to rural areas and of extending compulsory attendance in city schools. At present, those with lower levels of intelligence readily find a place in the family and community. Families of middle and higher socioeconomic level, however, whose children attend private schools and for whom parental ambitions are evident, are asking for help with the unusual child who fails to learn like other children.

In Turkey, in contrast, with about 70 percent literacy, where urbanization, industrialization, higher standards of living, and public education have been developing for 30 years of the republic's regime, the intellectual demands of the home, the school, and vocations are operative. Retarded children unsuccessful in school have become the concern of city school administrator and parents. Hence, about six years ago the Turkish Ministry of Education inaugurated pilot projects in the capital city of Ankara to discover, study, and teach retarded children.

This reviewer is led to conclude from her experiences and Seymour Sarason's penetrating analysis of cultural factors that cultural factors offer one of the most fruitful areas of research. (See Masland, Sarason, and Gladwin: *Mental Subnormality,* Basic Books, 1958, pp. 212-277.) Sarason is concerned with those factors, negative and positive, operative in intellectual development from early infancy and the relationship of degree and kind of intellectual ability to the demands of a particular society. Knowledge and understanding of cultural factors such as Sarason proposes would have bearing on every service, but particularly on diagnostic services, parent counseling, and education from the early years on.

This text will be valued by the professional worker in the field for its historical approach. It should be widely read by others having professional, personal, or social interest in the mentally retarded. It will help to allay doubts and assure the lay reader that with appropriate services the majority of the retarded can grow up to become social assets and that for the others research will discover better methods of treatment.

Other Books Reviewed

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Care of the Patient with a Stroke; A Handbook for the Patient's Family and the Nurse

By: **Genevieve Waples Smith**

1959. 148 p. illus. Springer Publishing Co., 44 E. 23rd St., New York 10, N. Y. $2.75.

From her many years' experience as a nurse and from knowledge gained in the day-to-day care of her husband after he suffered a stroke, Mrs. Smith offers practical solutions to problems in the rehabilitation of such patients. Not only are all aspects of daily physical care discussed but consideration is given also to the psychological problems of the patient and his family. Routines for daily care, training in ambulation and daily living activities, the problem of visitors and social activity, the handling of personality problems, speech loss and retraining, diet suggestions, general nursing technics, and the use of exercise and massage are discussed and illustrated. The book should be of great help to families in developing understanding of the needs of the stroke patient.

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Foredrag ved 2den Nordiske Konferanse om Cerebral Parese, Oslo, 24-25 August 1957

Edited by: **Bjarne Andersen** and **Kjell Boysen**

1959. 159 p. figs., tabs. Foreningen til Bekjempelse av Cerebral Barneparese, Oslo, Norway.

More than 200 participants from Finland, Denmark, Norway, and Sweden attended the Second Northern Conference on Cerebral Palsy in August, 1957. Achievements in medical research, education, training, and vocational rehabilitation were discussed by doctors, therapists, teachers, and parents. Main subjects on the agenda were: perinatal lesions and their significance in cerebral palsy; prognosis assessed by results of treatment; intellectual and mental conditions; social legislation with special bearing on cerebral palsy; education; training; choice of vocation; social contact.

Text of the proceedings is in the Norwegian language with a brief summary of the conference given in English.

528
Hearing; A Handbook for Laymen

By: **Norton Canfield, M. D.**

1959. 214 p. Doubleday & Company, Inc., Garden City, N. Y. $3.50.

The first volume in the new *Layman's Handbook Series* on disease and abnormal health conditions, this book by a physician who is also president of the Audiology Foundation offers an authoritative analysis of hearing handicaps, their causes, types, and treatment. He discusses as well the psychological, economic, and social problems caused by hearing impairment, special problems of children, modern surgical technics that can cure or improve hearing impairment, advances in hearing aids, and the work of hearing rehabilitation centers.

529
Help for Ten Million; A Manual for Patients with Arthritis, Rheumatism and Gout

By: **Darrell C. Crain, M. D.**

1959. 251 p. figs. Paperbound. *(Keystone Books in Medicine)* J. B. Lippincott Co., E. Washington Square, Philadelphia 5, Pa. $1.45.

Written for the patient suffering from arthritis or other rheumatic diseases, this manual discusses, first, the nature and forms of true arthritis and various miscellaneous rheumatic diseases; the second half is devoted to the causes and clinical course of gout, as well as prognosis and treatment. Dr. Crain explains in nontechnical language the rationale of treatment, the role of diet in controlling the diseases, the effects of climate, and the use of various drugs. Appendixes contain a variety of diet lists that the arthritic and gouty patient will find useful and a description of exercises to help overcome stiffness and increase motion in the joints. The author stresses, however, that this is not a "do-it-yourself" book for self-treatment; it is most helpful when used under the direction of the physician treating the arthritic patient.

530
Let's Play Hide and Seek (Together with: *Manual* for *Let's Play Hide and Seek* and *Guess What!*)

By: **Ruth M. FitzSimons,** Ed. D., and **Albert T. Murphy.**

1959. (16) p. illus. (*Manual . . .* 49 p.; *Guess What!* 51 p.) Expression Co., Magnolia, Mass. $6.00 for *Let's Play Hide and Seek* (with *Manual*); $1.00 for workbook *Guess What!*

An activities kit designed for speech work with children from six to nine years of age, it consists of a hardboard easel measuring 14 in. by 17 in., spiral bound for convenience in handling. Ten illustrations on heavy colored paper are reproductions of original water colors by Ruth Beaton, a professional artist, and depict various situations of interest to children. Small pictures incorporated within the large illustrations represent words beginning with the 11 practice sounds. The manual describes the purpose and uses of the illustrations and methods to be employed in therapy. Riddles for each of the 129 "hidden words" add to the "game" element of the practice work. The workbook *Guess What!* presents 129 additional riddles and pictures, utilizing the 11 practice sounds. The reading vocabulary of the riddles is on the first-grade level. The material provides practice in lipreading for the hard of hearing and necessary practice for the child with an articulation problem. Auditory, visual, and tactile cues enforce learning without the monotony usually experienced in repetitious drill.

531
Orthopedic Nursing Procedures

By: **Avice Kerr**

1959. 364 p. illus. Springer Publishing Co., 44 E. 23rd St., New York 10, N. Y. $4.75.

A handy reference book set up in outline form for ease of use, describing procedures used in orthopedic nursing and defining the general objectives, special psychological problems, and requisites for good bedside care. A special section is included on body mechanics for the nurse, to aid in the prevention of undue strain and fatigue while performing her duties. Special equipment demanded in orthopedic nursing is illustrated and its use explained. In addition to procedures for specific conditions, chapters cover postoperative amputation care, crutch walking, the principles of exercise and treatments generally falling within the scope of physical medicine, and complications of both a physiological and psychological nature. The section outlining procedures for discharging patients and formulating home-care instructions should be of value to the nurse charged with this responsibility.

532
Studies in the Vocational Adjustment of Deaf-Blind Adults

By: **U.S. Office of Vocational Rehabilitation** and **The Industrial Home for the Blind**

1959. 324 p. illus., tabs. (*Rehabilitation of deaf-blind persons, Vol. V*) Industrial Home for the Blind, 57 Willoughby St., Brooklyn 1, N. Y. $3.00.

Findings of the Industrial Home for the Blind—Office of Vocational Rehabilitation Deaf-Blind Study will be

of interest to administrators and workers in agencies serving this group of the handicapped, as well as to the local community seeking to place the deaf-blind in employment. Two years of intensive study have resulted in a detailed report of the factors limiting employment for the deaf-blind and characteristics of those persons who have been able to function in the work situation. Occupational opportunities open to the deaf-blind and methods of vocational evaluation, counseling, training, and placement are discussed at length. Possible solutions for a few of the practical problems arising during vocational adjustment of the deaf-blind are considered. Part II, on "The Workshop Adjustment of Deaf-Blind Men," analyzes data from a specific study of 23 males enrolled in a training program at the Industrial Home for the Blind workshop; 16 of the group had previous employment. Conclusions and recommendations based on data presented in the study are offered as guides for those planning services for the deaf-blind. Data from a survey of 12 deaf-blind persons employed in work settings other than the Industrial Home for the Blind are analyzed. It would appear that the deaf-blind have as much employment potential for sheltered work in social agencies and industry as the blind person with hearing; their potentialities for full-time, nonsheltered employment seem to be less favorable, however.

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The Treatment and Prevention of Reading Problems (The Neuro-Psychological Approach)

By: **Carl H. Delacato**

1959. 122 p. illus. Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. $4.50.

The author (Director of Psychological Services, Rehabilitation Center of Philadelphia), as a teacher, school administrator, diagnostician, and psychologist, has considered many approaches to the problem of nonreading or poor reading ability in children. He conducted a series of studies using various accepted systems as remedial procedures in work with slow readers. With each system, however, there still remained those who continued to present reading problems. An analysis of the characteristics common to poor readers led to the belief that a possible neurological basis might be responsible for poor language and reading development. Only efficient neurological functioning on the unilateral level could bring about improvement in basic language deficiency, he believed. Such factors as sleep patterns, tonality, handedness, visual control, musical ability, footedness, dominance, fluid levels, carbon dioxide retention, and reflex serialization were studied in relation to neurological organization in man. His neuropsychological approach to the treatment and prevention of reading and language disorders is in the nature of a preliminary report and suggests possibilities for further research in this area. Included are specific recommendations for preventing reading problems through proper management of children from birth on.

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Tuberculosis Medical Research; National Tuberculosis Association, 1904-1955

By: **Virginia Cameron** and **Esmond R. Long**

1959. 325 p. figs. *(Historical ser. no. 9)* National Tuberculosis Association, 1790 Broadway, New York 19, N. Y. $5.00.

Voluntary organizations planning to include medical research as a part of their programs will find this account of the historical development of the National Tuberculosis Association's medical research program of interest. Although the Association was organized in 1904 it was not until 1921 that sufficient funds were available to launch the research program. In addition to the history of the program, a brief summary of the individual investigations supported by the Association is included, with a review of the administrative and financial aspects of conducting a research program. A bibliography of publications by grantees and fellows of the program is also given (p. 257-308). The book should serve as a valuable reference to early investigative studies in tuberculosis and related fields.

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Vocational Rehabilitation for the Physically Handicapped

By: **Louise M. Neuschutz**

1959. 136 p. illus. Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. $5.75.

Rehabilitation problems of the physically handicapped and the older worker in the area of employment are discussed by the author, who has derived her material from a variety of sources. The book is intended for use in public education and as a reference source for the handicapped person and vocational counselor.

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

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Considering the Aged

By: **A. L. Chapman,** M. D. *(U. S. Public Health Service, Washington 25, D. C.)*

In: *Public Health Rep.* April, 1959. 74:4:333-337.

The ratio of older to young persons treated in hospitals, in clinics, and by visiting nurse programs has become increasingly larger. Anyone in public health work or private medical care now finds himself a practicing gerontologist. More than ever the public health practitioner must be prepared and willing to accept the new responsibilities imposed on him by an aging population and to find new ways of working with other concerned professions.

Control of chronic disease has been described as the maximum application of existing knowledge and resources to reduce the impact of chronic disease on the individual, his family, and society. Five levels of control have been proposed by Dr. Hugh R. Leavell and Dr. E. Gurney Clark: health promotion, specific protection (primary prevention), limiting the extent of disability, and rehabilitation. With the growth of health and medical services for the older person, other agencies and personnel will be found to be contiguous. Thus, basic planning for health must include cooperative action in housing, employment, recreation, and education.

Deterrents to a community health program for the chronically ill and aged are largely socioeconomic. They may appear in the form of: *(a)* the personality of the older person, *(b)* his social and cultural background, *(c)* his economic status and ability to pay for services, *(d)* the attitude and orientation of the community, its leaders, and professional groups, and *(e)* the availability of community resources and services. Important also is the attitude of aging persons toward preventive medicine; they have been reluctant to participate in many different kinds of preventive programs, partly because "What I don't know won't hurt me," and sometimes because the past and present hold more interest than the future. The answer may lie in prepaid health insurance plans, but "selling" such plans is difficult.

An estimated 300,000 aged persons are now being cared for in some 25,000 nursing homes and related facilities, with nursing care the predominant need for the chronically ill. Many older people still remain in general and special hospitals, particularly mental institutions, since not enough nursing homes are available. Qualitative control of nursing homes by licensure, inspection, and establishing standards has become predominantly a public health function. But, this is not enough. Nursing home personnel must be recruited and trained; the community must be educated as to these needs.

The solution of the nursing home problem will not solve the care of the chronically ill older person. Last year about 80 percent of the more than 2 million aged who were disabled for 3 months or more received care in their own homes. This may not have been too difficult for those with relatives, but, for the many men and women living alone in inadequate quarters, home care is impractical, however desirable. Organized home care programs are finding that more than medical and nursing care is needed in the home; homemaker or housekeeping services are required also. Some homemaker programs try to meet the need of older persons, but the demand is too great. Other ways must be developed, such as use of foster homes or new facilities for graduated and selective care tailored to the immediate needs of each patient.

A facility giving such care is the Manchester Memorial Hospital in Connecticut. The Public Health Service is currently studying the care given there for *(a)* the critically ill patient, *(b)* those not dangerously ill, and *(c)* those who are ambulatory and capable of self-care. Long-term care is given by an adjoining unit. Home care has been begun.

A step toward better care of the homebound stroke victim was recently taken by the Public Health Service. Its Chronic Disease Program has prepared a booklet *Strike Back at Stroke.* Based on the family physician's prescription, it is an illustrated instruction manual for the patient's family to assist them in his care. Members of the family may aid the patient in early ambulation and active and passive exercises, thus saving the time of professional workers and preventing deformity and disability.

The older person is helped in his own home by community programs such as "Meals on Wheels," which serves hot, nutritious meals in the homes of older persons incapable of preparing their own meals. Recent studies in urban communities demonstrate that homebound older

patients prefer assistance such as marketing and personal errands or companionship to meals served at home. Aged persons still desire a degree of independence regardless of disability. Thus, friendly visiting programs or housekeeping services are needed.

Public health workers aiding in conserving the health of these persons cannot ignore their needs in food, clothing, and shelter, nor can they ignore the interdependence of health and leisure, employment, and social relationships. In attaining the optimum adult hygiene, help must come from medicine, public health, and the social sciences.

Health specialists should be trained in chronic disease and aging by two means: formal, long-term courses for professional workers prior to their entrance into public health, and short-term refresher or "re-tread" courses for those already in the field. A recent study of the curriculum of schools of public health revealed that a surprising amount of time was spent in lectures, seminars, field visits, and student assignments on chronic disease and aging. Professional training is exposing public health workers to basic concepts and problems relating to the chronically ill and aged person. Short-term training is gaining momentum also. Participants acquire new skills and knowledge and the courses have stimulated interest and given impetus to community programing.

Public Health Reports is issued monthly by the Public Health Service, subscription rate $4.25 a year ($6.00 foreign), 55c a copy. Order from U.S. Superintendent of Documents, Washington 25, D.C.

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Report on the Partially Sighted Adopted by the Joint Committee on the Rehabilitation and Resettlement of the Disabled

Issued by: **Social Section, Western European Union, London**

Feb., 1959. 17 p. Mimeo.

In general, the majority of countries represented by delegations from the Western European Union (W.E.U.) consider a child partially sighted when he cannot follow the normal regime of ordinary schools in spite of corrective measures but can use his sight for educational purposes with use of special methods. An adult is considered partially sighted if he is handicapped in apprenticeship for trades, has a limited choice of occupation, or has to give up his normal work but may still be able to follow a trade involving the use of sight. Some of the countries have defined the range of partial sight on the basis of corrected vision in the better eye, starting from the limit below which a person is considered blind. These limits are: Belgium, from 1/20 to 4/10; France, 1/10 to 4/10; Italy, 1/10 to 1/4; Federal Republic of Germany, 1/50 to 5/20; and United Kingdom, 3/60 to 6/24 (Snellen scale). Other factors are sometimes taken into account.

Although there is no provision generally for compulsory registration or for systematic detection of partial sight before school age, most of the W.E.U. countries have a schools medical inspection service. The percentage of partially sighted in the school population has been estimated at 1/1,000 in France and Belgium; 2.5/1,000 in Italy (Milan); 1/5,000 in Luxembourg; 1/1,000 to 3/1,000 in the Federal Republic of Germany; and 1/4,000 in the United Kingdom. In all, prior consent of the parents is necessary for the admission of a child to an institution for the partially sighted, with responsibility shared by the authorities. The opinions of the general practitioner and the specialist are ultimately the deciding factor. Belgium, France, Luxembourg, the Federal Republic of Germany, and the United Kingdom recommend admission at about 5 to 6 years of age. However, Belgium advises admission at age 3, and Germany recommends adaptation prior to school.

The countries have varying arrangements for day schools (schools or special classes in conjunction or otherwise with ordinary schools or schools for the blind). All but the United Kingdom run boarding schools (special schools or in conjunction with normal classes or classes for blind children). The French, Federal German, and Netherlands delegations favour special boarding schools and advise against classes for partially sighted children at day or boarding schools for the blind.

In Belgium, Luxembourg, Italy, and the Federal Republic of Germany, the Ministry of Education is responsible for institutions and classes for the partially sighted. In the United Kingdom, special schools are administered by local education authorities or by voluntary organisations; all are subject to regulations made by the Ministers concerned. In the Netherlands, all establishments are run by trusts, associations, or congregations. In France, classes at ordinary primary schools or government schools for the blind are under the Ministry of Education. A number of private institutions for the blind with special classes for partially sighted children are controlled by the Ministry of Public Health and Population. Also in France a number of special schools for the partially sighted are run by private organisations but staffed by the Ministry of Education.

The delegations agreed that all classes for the partially sighted should be small (8 to 15 pupils) and that classrooms should be spacious, airy, and well-lit with maximum light and minimum dazzle. As far as possible sunlight should be used, with indirect lighting preferred to incandescent lighting. A single source of light to the left of the pupil (at least 250 lux) is most satisfactory.

For certain types of work, the blackboard and each desk should be lit. In decoration, light, plain colours restful to the eyes (white or off-white for ceilings, buff, yellow, or steel-gray pastel shades for walls), matt and nonshiny finish, are preferred. Teaching equipment should be adapted to the child's vision. The furniture and equipment agreed on are:

A large number of adjustable boards, matt finish, in black, with yellow or white chalk for contrast (France, United Kingdom); green (Belgium).

Individual desks with adjustable unvarnished tops.

Nonfolding chairs and individual cupboards.

Brightly coloured signboards in classrooms, corridors, and entrances (Germany).

A school museum with detailed reproductions of certain objects not easily observed, *e.g.*, parts of body and certain objects used in engineering, electricity, and chemistry.

Spectacles, magnifying glasses, large-print typewriters, manuscripts in large characters, and exercise books with pale-yellow, squared paper.

In Belgium, those with seriously failing sight are taught in the same way as the blind and others are taught so as to use the sight remaining. In France special instruction is based on active methods designed to arouse the child's interest and confidence and is mainly individual and oral. In the Netherlands the teacher from the first works for confidence and attempts to train the child to hold his own with the normal. Special material is used at the start and ordinary books are introduced as soon as possible. It was agreed among the delegations that the fullest possible use should be made of nonacademic and recreational activities.

In the United Kingdom, no special qualifications are required for teachers of the partially sighted, although short courses are held. The other countries require some form of special training. It is felt that specialisation is necessary so that teachers are trained in individual methods of instruction, can use teaching material, and can work with the eye specialist and apply his advice to the greatest advantage. The delegations of Belgium, France, the United Kingdom, and the Federal Republic of Germany believed that liaison between the staff and the medicosocial team and the family is essential.

In most W.E.U. countries, vocational guidance for the partially sighted is empirical in method. There are no special teams, but the various experts concerned cooperate. Delegations recognise that modern methods of vocational guidance can be applied with slight alterations, as in use of test papers printed in large type (Belgium), special tests of the manual dexterity needed by a partially sighted person to compensate for his defective vision, and acoustic tests in cases of extremely limited vision (Federal Republic). Methods should be suited to the degree of vision, level of intelligence, aptitude, health, environment, and character of each partially sighted individual.

It was pointed out that *(1)* training for a trade practiced by the sighted should not be undertaken without allowing for the fact that vision may be further impaired and *(2)* persons should not be directed to a trade for the blind in which work opportunities are limited. The following were considered trades open to the blind and suitable for those with little residual vision: chair caning, basket-making; massage; music; piano tuning; telephone operating; horticulture; gardening. New openings, according to degree of vision, exist; the partially sighted may be a: businessman; industrialist; university lecturer; storekeeper; plastic industry worker; precision engineer; tile-layer; saddle-maker; leather and harness-worker; frame-maker; corset-maker; linen maid; florist.

Most delegations felt that the partially sighted who are directed to careers for the sighted should not be trained with the blind. In Belgium, they receive vocational training in groups, and methods and equipment are adapted to the degree of handicap. France also suggests this. In other countries vocational training alongside normal children is permitted, since equipment need not be specially adapted (Netherlands).

There are no special placing services for the partially sighted in W.E.U. countries. In some member states, services deal with both the blind and the partially sighted, but, in the majority of cases, all categories of physically handicapped persons are dealt with together. As a general rule, few enquiries have been carried out after employment has been found, but most delegations favour methodical investigations being made among placing services and employers. In Belgium, most encouraging are results in certain trades such as the making of spring mattresses and operation of telephone switchboards. In France, limited enquiries indicate satisfactory results. In the Netherlands, the employment service keeps in touch with all handicapped persons for six months after placing and contacts employers; in this way failures are ascertained and serve as guides when other employment is sought. Very little information is available on employment of the partially sighted in public service.

In all countries the state contributes toward boarding expenses for partially sighted pupils. Generally tuition fees are also paid by the government or governmental branches. The countries also give financial assistance to those who cannot be assured of a living wage or cannot find employment at all.

Correspondence relating to the report of the Joint Committee may be directed to Miss E. C. Corry-Smith, Head of the Social Section, Western European Union, 9 Grosvenor Place, London, S. W. 1, England.

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Feeding Elderly People in Their Homes

By: C. Elizabeth Henry, Nutrition Consultant

In: *J. Am. Dietetic Assn.* Feb., 1959. 35:2:149-151.

Since February, 1958, the Visiting Nurse Service of Rochester and Monroe County, Rochester, N.Y., has been administering a home food service for the elderly who are unable to shop or prepare adequate meals, regardless of economic need. If family assistance is available, service cannot be provided. This program is the result of a contract with the Bureau of Chronic Diseases and Geriatrics of the New York State Department of Health, with the deficit of the pilot project for the period up to March 31, 1961, being assumed by the Bureau.

Two meals, one hot, are delivered Monday through Friday. Clients must provide their own breakfasts and meals must be available to them on week-ends. Clients range in age from 45 to 96 years, the median being 79, the average 76.8, and the mode 80. Sometimes hospitals contact the service for convalescent patients and private physicians make direct referrals. The full fee is $1.25 a day, but it may be adjusted down to 50 cents. The Monroe County Department of Social Welfare has agreed to budget the costs for its clients certified for the service. Fifty-seven percent of those served pay the full fee. Before service is started, a public health nurse supervisor investigates the need for service of prospective recipients, explains the service, and makes arrangements. Each month she visits the client for re-evaluation of need and sells a ticket for the next month.

Food is prepared in a centrally located kitchen directed by the nutritionist of the Visiting Nurse Service. A part-time cook is also paid. Lay volunteers, who work one day a week, package food and deliver. The professional staff of the service handle administration and routing. Eight volunteers and four cars are used from 11:45 A.M. to 1:15 P.M. One volunteer drives and a partner delivers. Two additional volunteers arrive at the kitchen at 10:00 A.M. to package desserts and salads, make sandwiches, and help pack the cold and hot insulated carrying boxes. An active chairman of volunteers recruits, orients, and trains the women.

The food is simple, without sauces and gravies. The dinner includes meat, potato, vegetable, salad, bread, dessert, and a choice of beverage. The supper is a protein sandwich, fruit, and milk. About three-fourths the daily recommended allowances for a man of 65 years of age is provided. Modifications allow for those with diabetes or who are moderately restricted in sodium intake. The caloric level of the meals is 1,200 to 1,400 calories. Nutrient standards are met, except possibly that for ascorbic acid since citrus juice cannot be served and the fruit is not always in season. Instead, tomatoes, grated cabbage, and fresh fruits are served frequently. It is planned to use citrus fruits as much as possible in salads and fruit cups. The suppers must be prepared so that they withstand room temperatures for as long as four hours. Mayonnaise cannot be used.

All-paper service is used. Foods for the cold bag are refrigerated until packing time. Lunches are packed in paper bags and placed in insulated carrying boxes, one per route. Noon beverages are carried in quart thermos bottles. Coffee, tea, or milk is poured at the home by the volunteer. The carrying box and insulated bags for hot food are preheated. The hot food is placed on a paper plate, which is covered, stapled, and put in the insulated bag. The bags are stacked into the carrying box—one for each route. Nine dinners is the maximum carried on the route.

Acceptance of the service has been good with little reported waste of food. The volunteers report visible improvement in the appearance, movement, and "spryness" of the clients. Clients have expressed their appreciation. Some have gained needed weight. It is planned to evaluate the service to the clients and to make a nutritional study of selected recipients. In cooperation with the New York State Department of Health, a manual will be prepared for use in setting up similar programs elsewhere.

The Journal of the American Dietetic Association is published monthly by the Association, 620 N. Michigan Ave., Chicago 11, Ill., subscription $8.00 a year, U.S., Canada, and countries of the Postal Union (other countries, $9.00 a year).

Forthcoming

In the August issue of *Rehabilitation Literature*, the Article of the Month will be "Facial Disfigurement, a Major Problem in Rehabilitation," by John Marquis Converse, M. D., Clinic for Reconstructive Plastic Surgery of the Face, Manhattan Eye, Ear and Throat Hospital, New York, N. Y.

In the September issue *Rehabilitation Literature* will publish as its Article of the Month "Special Education Problems in Western Europe," by Wallace W. and Isabelle Taylor. Dr. Taylor is Professor of Education at the State University College for Teachers in Albany, N. Y., and Mrs. Taylor is Chairman of the Department of Psychology at Russell Sage College, Troy, N. Y.

Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

AMPUTATION—EQUIPMENT—RESEARCH

539. California. University. Child Amputee Prosthetics Project

Fourth annual report . . . 1958. Los Angeles, Univ. of California School of Medicine, 1958. 42 p. illus., tabs. Mimeo.

The Child Amputee Prosthetics Project, established at the University of California, Los Angeles, in 1946, was expanded in 1955 through a grant from the U.S. Children's Bureau; research since 1955 has encompassed the fields of medicine and surgery, social work, psychology, occupational and physical therapy, engineering, and prosthetics. With the addition of qualified personnel during the past year, an interdisciplinary approach to the treatment of child amputees is now possible. Information in this report covers a description of the patient population for 1958 with a classification of types of amputations and congenital deformities, clinical experience, reports of group studies on prosthetics and their evaluation, special devices designed by the Project, and methods of dissemination and acquisition of information during the year.

ART

540. Jokl, Ernst *(Dept. of Physiology, Univ. of Kentucky, Lexington, Ky.)*

Studies in clinical physiology of exercise, III: A tetraplegic artist (case history, with reference to the problem of mobilization of latent neuro-motor resources), by Ernst Jokl, Herta Lange-Cosack, and Dolores Little. *J. Assn. Phys. and Mental Rehab.* Mar.-Apr., 1959. 13:2:47-49, 63.

Clinical evidence presented in this case history suggests the possibility of motor resources, latent in form, that are often great enough to be a decisive factor in the handicapped person's rehabilitation. The human mind frequently has the capacity to abstract mental images and to project them alternately and vicariously through any part of the motor system available. Extraordinary physical achievements of the physically handicapped are proof that some have been able to mobilize patterns of a different and superior quality than those developed by the majority of the disabled and nonhandicapped.

ARTHRITIS

See 529.

BLIND—INSTITUTIONS

541. Paraskeva, Peter C.

A survey of the facilities for the mentally retarded-blind in the United States. *Internatl. J. Educ. of the Blind.* May, 1959. 8:4:139-143.

A report of a survey of residential schools for the blind in the United States and Hawaii to determine available facilities for mentally retarded (educable, IQ 50-75) blind children (those with 20/200 vision in the better eye with maximum correction). Of the 29 schools responding to the questionnaire, 90 percent have accepted these children in their respective schools; there are few residential schools in the United States that have not recognized the need for programs for these children. Approximately 15 percent of the population of average residential schools having 150 students are doubly handicapped in this manner. Institutions for the mentally retarded in the United States that accept visually handicapped children are more numerous than those refusing to accept the visually handicapped. Few state schools prohibit by law the acceptance of the mentally retarded in schools for the blind. More than half the reporting schools provide a special class for this group. Additional reimbursement is not made by the majority of states to schools accepting these children. A majority of schools report no occupational educational program as such for students.

BLIND—MENTAL HYGIENE

542. Bauman, Mary K. *(1604 Spruce St., Philadelphia 3, Pa.)*

The initial psychological reaction to blindness. *New Outlook for the Blind.* May, 1959. 53:5:165-169.

Differences between self-concept and the demonstrated self lead to bizarre behavior when differences are extreme. When blindness occurs in an adult, the initial psychological reaction will depend on how nearly his concept of a blind person fits his concept of himself. Where the individual can find no similarity between the two concepts, he will attempt to deny the visual loss. Where loss of vision is so great that denial is impossible, the loss may be admitted on a temporary basis; temporary acceptance is a frequent family reaction to the person's blindness. Apathy exhibited by the newly blinded most likely reflects a feeling of intense loss of self-concept. The author discusses technics for helping the blind person to accept his loss of vision in a realistic manner by altering self-concepts. By concentrating on differences and planning counseling in areas of most concern to the individual, the counselor is more apt to achieve successful results in rehabilitation efforts.

BLIND—SPECIAL EDUCATION

543. Nolan, Carson Y. *(1839 Frankfort Ave., Louisville 6, Ky.)*

Achievement in arithmetic computation; analysis of school differences and identification of areas of low

achievement. *Internatl. J. Educ. of the Blind.* May, 1959. 8:4:125-128.

Presents a further analysis of data from a study of a Braille adaptation of the Arithmetic Computation Tests from the Stanford Achievement Tests (see *Rehab. Lit.*, May, 1959, #370). An attempt was made to determine differences in achievement between children attending various schools for the blind and to identify tentatively the types of arithmetic computation problems for which achievement is low. Statistically significant differences in achievement were found to exist between schools, but individual schools were relatively stable in levels of achievement. Varying rates of progress in achievement appeared to exist among schools. Areas of low achievement in arithmetic computation were identified through examination of item difficulties. This elementary analysis of data may be useful to educators of the blind in evaluating their respective programs.

See also 581.

CAMPING

544. Rotter, Paul *(Lexington School for the Deaf, 904 Lexington Ave., New York, N. Y.)*

Camping for deaf children. *Volta Rev.* May, 1959. 51:5:209-211, 227.

In same issue: Teach your child the language of games, Mary R. Haney. p. 212-213.

The author, assistant to the Superintendent of the Lexington School for the Deaf, has charge of work with parents there. He discusses the advantages of camping experiences for deaf children; factors parents should consider in the choice of a camp; emotional, physical, and social readiness of the child for camping experiences; preparation of the child for participation in camping; and the respective advantages of both day and residential camping.

Mrs. Haney discusses the need of the deaf child for social skills; communication skills and a knowledge of the rules and languages of games aid the child in becoming an accepted member of the neighborhood group. Because school time is limited, parents will have to teach the deaf child these particular skills. Methods for teaching the deaf children to play the card games are discussed briefly.

CEREBRAL PALSY

See 527.

CEREBRAL PALSY—DIAGNOSIS

545. Rosner, Samuel *(1882 Grand Concourse, Bronx 57, N.Y.)*

Porencephaly and complicated cerebral palsy. *Arch. Pediatrics.* Nov., 1958. 75:11:486-489.

Possible causes of porencephaly are reviewed briefly and a complicated case of cerebral palsy due to bilateral porencephalic cysts is presented, including the clinical history, operative findings, and the post-mortem description of the brain. The patient was a 17-month-old child with cerebral palsy, gross mental defect, and severe grand mal epilepsy.

CEREBRAL PALSY—INSTITUTIONS

546. Houtz, S. J. *(10362 Morrow Circle S., Dearborn 1, Mich.)*

Integrated staff program planning to improve care for the child with cerebral palsy, by S. J. Houtz and M. Genevieve Blakeley, *Phys. Therapy Rev.* May, 1959. 39:5: 299-303.

An analysis of the Detroit Orthopaedic Clinic Nursery Schools' program for cerebral palsied children, made in 1956, led to the establishment of an integrated plan of services for preschool children. A review of the evaluation and group placement program, following two years' experience, is given; benefits of the present program are compared with those of the past 30 years. Staff coordination aids both staff and parents in long-term planning; reports from each professional discipline have demonstrated areas of progression and regression. Children have exhibited improved personal-social behavior. Close cooperation between the mother, caseworker, and therapist has resulted in better home treatment programs. Because of the success of the plan with preschool children, similar group programs are being developed for older children through adolescence. A prevocational group is already established.

CEREBRAL PALSY—PSYCHOLOGICAL TESTS

547. Jewell, B. T. *(435 S. La Cienega Blvd., Los Angeles 48, Calif.)*

How valid is "childhood-environment determinism"? The case of Jim, by B. T. Jewell, H. Wursten, and Cynthia Blackburn. *J. Projective Techniques.* Dec., 1958. 22:4: 402-414.

Case material is presented concerning the personality development of a young man with cerebral palsy of the athetoid type who was subjected to traumatic experiences of a social nature in early childhood. Theoretically his childhood experiences should have contributed toward producing a grossly inadequate personality with poorly defined ability to deal with the world; the "childhood-environment determinism" theory is not applicable in this case. The authors suggest that practitioners working with children handicapped by physical disability or an unhealthful environment need not assume that prognosis is poor in such cases. Further research is needed in specific cases and circumstances where persons have matured and function well in spite of adverse conditions of childhood. An expansion and improvement of current personality theories is also needed.

See also 586.

CEREBRAL PALSY—SPEECH CORRECTION

548. Clement, Mary *(30 Warren St., Brighton, Mass.)*

Dysarthria in cerebral palsy, by Mary Clement and Thomas E. Twitchell. *J. Speech and Hear. Disorders.* May, 1959. 24:2:118-122.

Presents an analysis of the deficits in phonation, articulation, and respiration in patients with infantile spastic quadriparesis and in patients with congenital bilateral athetosis uncomplicated by the presence of spasticity. Twenty patients ranging in age from 3 to 12 were selected for study. Certain common physiological factors account-

ing for dysarthria in both groups were found but closer analysis revealed differences in the speech deficit in the two groups. It would appear that the speech mechanism has positive and negative reactions analogous to the groping and avoiding responses of the limbs and that similar alteration of these responses in these syndromes offers a physiologic explanation for associated dysarthria. The patient with athetosis may learn to speak more readily than the patient with spastic quadriparesis but will still be hindered by the difficulty of controlling the two antagonistic reactions.

CEREBRAL PALSY—SURVEYS—NEW YORK

See 591.

CHRONIC DISEASE—NEW YORK

549. Brightman, I. Jay *(11 N. Pearl St., Albany 7, N.Y.)*

Young and middle-aged adults in long-term care facilities. *N. Y. State J. Med.* Mar. 15, 1959. 58:6:1017-1023.

A report of findings of a survey of long-term care facilities in New York State (proprietary nursing and convalescent homes and public home infirmaries) made to determine the prevalence of young and middle-aged adults being cared for. From information received, it was found that a high proportion of these patients were in fair to good condition and were either ambulant or semiambulant. Many of the younger individuals had good potentialities for rehabilitation, either vocationally or toward increased self-sufficiency. The scarcity of social, recreational, and rehabilitative activities in the majority of nursing homes works a particular hardship on younger patients in facilities where the average age of patients is most often 70 years or older. Some suggestions for providing programs or facilities to meet the needs of younger patients in long-term care facilities are offered.

CYSTIC FIBROSIS

550. Tappan, Vivian *(Yale Univ. School of Medicine, New Haven 11, Conn.)*

Management of children with cystic fibrosis. *Nursing World.* May, 1959. 133:5:18-20.

Total management of the child with cystic fibrosis should be adjusted to meet the changing needs of the individual child; medical and nursing personnel at Yale University School of Medicine explain to parents the necessity for flexibility in treatment. Physical therapy and inhalation therapy are transformed into games performed by the children; many of the therapeutic measures can be carried out by indirection without the child realizing that he is receiving necessary treatment. The management of pulmonary and nutritional disturbances is discussed briefly.

DEAF—PERSONNEL

551. Rotter, Paul

A review of the literature pertaining to the preparation of teachers of the deaf. New York, The Author, n.d. 20 (19) p. Mimeo.

The history of preparation of teachers of the deaf since 1872 when Alexander Graham Bell established the first such classes at Boston. The second half of the paper discusses the development of the curriculum in teacher training for work with the deaf. In reviewing the literature, the author found evidence of a variety of teacher preparation programs in existence, many of which had inadequate professional standards at the time of R. G. Brill's study, made in 1950. Present programs, however, follow the basic outlines established by national organizations representing the field. 97 references.

Available from *American Annals of the Deaf,* Gallaudet College, Washington, D.C., at 25¢ a copy.

DEAF—PSYCHOLOGICAL TESTS

552. Goetzinger, C. P. *(Dept. of Hearing and Speech, Univ. of Kansas Med. Center, Kansas City, Kan.)*

Educational achievement of deaf children, by C. P. Goetzinger and C. L. Rousey. *Am. Annals of the Deaf.* Mar., 1959. 104:2:221-231.

Findings of a study to evaluate the general level of attainment on standardized achievement tests of congenitally deaf children and those with early, acquired severe deafness whose educational history revealed an almost total absence of preschool training and of consistent use of auditory stimulation through amplification. The effect of being educated in classes of 10 or more students was also discussed. No differences in educational achievement were found between children who had acquired severe deafness not later than age three and congenitally deaf children. The Binet-Vocabulary test, as administered, appears to afford a quick estimate of a deaf adolescent's educational level. No differences in educational achievement were found between children whose parents were deaf and those with hearing parents, except in the Arithmetic Computation subtest where the former excelled. The authors make some suggestions in regard to future research for residential schools for the deaf. 24 references.

DEAF—RECREATION

See 544.

DEAF-BLIND—KANSAS

553. Riley, Betty G. *(Am. Found. for the Blind, 15 W. 16th St., New York 11, N.Y.)*

A new plan in Kansas; its development and potential. *New Outlook for the Blind.* May, 1959. 53:5:161-165.

The development of services to deaf-blind children on a statewide basis in Kansas was the outgrowth of experiences of the University of Kansas Hearing and Speech Center in working with a severely handicapped child brought to the Center for treatment. To date, through a referral system set up cooperatively with the State Services for the Blind and the American Foundation for the Blind, nine deaf-blind children have been studied at repeated intervals over the past several years. Cooperative planning by a number of interested agencies in Kansas has resulted in recommendations for a program to meet the needs of deaf-blind children. It is hoped that the program will serve as a guide for other states wishing to initiate similar services. Legislation in 35 states provides educational aid for the deaf-blind but no state has developed a coordinated program of services, to the author's knowledge.

DEAF-BLIND—EMPLOYMENT

See 532.

DYSTONIA MUSCULORUM DEFORMANS

554. Cooper, Irving S. *(Dept. of Neurosurgery, St. Barnabas Hosp. for Chronic Diseases, New York 57, N.Y.)*

Dystonia musculorum deformans alleviated by chemopallidectomy and chemopallidothalamectomy. *A.M.A. Arch. Neurol. & Psychiatry.* Jan., 1959. 81:1:5-19.

Describes the clinical course of a disease that is progressively incapacitating and characterized by involuntary movements and deformities of the entire body. Previously considered to be unresponsive to medical, surgical, physical, or psychiatric therapy, dystonia musculorum deformans in children has been alleviated by sufficient-sized, accurately placed lesions in the globus pallidus and/or ventrolateral nucleus of the thalamus. In 13 of 16 children with advanced form of the disease, marked alleviation and reversal of the involuntary movements and deformities have been demonstrated following chemopallidectomy and/or chemopallidothalamectomy. Five case reports are included. Improvement has been sustained for more than two years in several patients. Psychologic studies have shown that intellectual functioning following operation was as high as before surgery. Implications of the results of this study are pertinent not only to cases of dystonia musculorum deformans but also to the widespread category of involuntary movement disorders of childhood.

EMPLOYMENT

See 535; 572.

EMPLOYMENT (INDUSTRIAL)—NEW YORK

555. Abilities, Inc. Human Resources Corporation

A study of the adaptability of disabled workers, by William J. Campbell, Raymond R. Leizer, and Harold E. Yuker. Albertson, N.Y., The Corp., 1958. (61)p. illus. *(Human Resources study no. 3)* Spiral binding.

The final report of a two-year study conducted by the staff of Human Resources Corporation under a grant from the U.S. Office of Vocational Rehabilitation, it presents findings on the adaptability of disabled workers at Abilities, Inc., a subcontracting industrial firm founded by Henry Viscardi, Jr., and employing only disabled persons at wages comparable to those paid in industry to nonhandicapped workers. In order to analyze the successful performance of handicapped workers in competitive industry, separate but related studies of the medical and psychosocial characteristics have been published concurrently with findings of this study (see *Rehab. Lit.,* Dec., 1958, #1301 and 1302). Background information on the study includes a brief history of the founding of Abilities, Inc., a classification of disabilities of employees, a description of hiring procedures, the development of the training program, and the adaptations in machine design and placement methods contributing to successful operation of the work force. The main portion of the report is concerned with job descriptions and technical information on actual construction of adaptations of machinery and equipment. Personal adaptations for comfort, health, and safety are also discussed and illustrated.

Available from Human Resources Corp., Abilities, Inc., Albertson, N.Y., at $1.00 a copy.

EXERCISE

See 540.

HANDICAPPED—EQUIPMENT

556. Montan, Karl *(Jutas Backe 1, Stockholm, Sweden)*

Technical aids in the rehabilitation scheme. *Prostheses, Braces, and Tech. Aids.* Spring, 1959. 4:4-7.

Mechanical aids, other than artificial limbs and supporting braces, should be prescribed with care to fit the actual need of the disabled person. Mr. Montan, a member of the International Society for the Welfare of Cripples' Committee on Prostheses, Braces, and Technical Aids, reviews briefly the current status of wheel chairs, aids for daily living activities, aids for work and household tasks, architectural adaptations, and therapeutic aids for functional training of the disabled. To disseminate information concerning technical aids, it is recommended that a more systematic collection of experimental data be attempted, that data be subjected to more extensive medical and technical research, and that wider distribution be given information concerning the indications and technic for application of available devices.

HARD OF HEARING

See 528.

HEART DISEASE—MEDICAL TREATMENT

557. Black, Asher *(695 W. Onondaga St., Syracuse 4, N.Y.)*

An evaluation of three revascularization procedures in the rehabilitation of the coronary patient, by Asher Black and J. Ernest Delmonico, Jr. *Am. J. Cardiology.* Jan., 1959. 3:1:68-73.

This report of a small but significant series of patients with advanced coronary artery disease treated by the surgical procedures of cardiopexy, internal mammary artery ligation, or the Beck I operation is of interest because of the current confusion and disagreement concerning the value and effectiveness of surgical treatment in such cases. Clinical improvement was noted in 30 of the 36 patients (83 percent); excellent results (complete or almost complete disappearance of angina) were observed in half the patients. Objective evidence of improvement as measured by electrocardiograms and ballistocardiograms is presented. Patients were, in many instances, able to tolerate marked increase in activity without pain and showed an increase in cardiac functional capacity and a decreased need for cardiac medicines, including digitalis in some cases. Surgery as a form of treatment for severe coronary artery disease is of value in selected patients.

HEMIPLEGIA

558. Lowenthal, Milton *(1 E. 105th St., New York 29, N.Y.)*

An analysis of the rehabilitation needs and prognoses of 232 cases of cerebral vascular accident, by Milton Lowenthal, Jerome S. Tobis, and I. Ray Howard. *Arch. Phys. Med. and Rehab.* May, 1959. 40:5:183-186.

A summary report of data obtained in a study of 232 cerebral vascular accident patients admitted during a one-year period to a 1,000-bed municipal hospital. The group represented four percent of all medical admissions to the Metropolitan Hospital, New York City, during 1957. Forty-two percent of the patients died, the majority within a two-week period following admission. Approximately 36 percent of the surviving group were discharged within a two-week period. About 75 percent of those remaining longer in the hospital received some rehabilitation care. Data on patient status at time of discharge are also given. Analysis of rehabilitation prognosis in the surviving patients indicated that the availability of rehabilitation services in the general hospital may favorably influence functional recovery of the hemiplegic patient.

HEMIPLEGIA—NURSING CARE

See 526.

HOME ECONOMICS

559. Connecticut. University. School of Home Economics

You can do family laundry—with hand limitations, by Gertrude Monhaut Zmola. Storrs, Conn., The University, n.d. (12) p. illus.

Illustrates equipment and procedures for simplifying laundry work when hand limitation necessitates adaptations in work routines. Illustrations are of a homemaker with left arm amputation performing activities involved in both hand and machine washing of soiled clothing. Material in the bulletin is based on studies in the area of Child Care Problems of Physically Handicapped Mothers, conducted by the School of Home Economics, University of Connecticut. Additional bulletins to help handicapped homemakers will be available as test results are evaluated. Single copies of this bulletin are available on request from Home Economics Research Center, School of Home Economics, University of Connecticut, Storrs, Conn.

HOMEBOUND—PHYSICAL THERAPY

560. Littauer, David *(216 S. Kingshighway Blvd., St. Louis, 8, Mo.)*

The role of the physical therapist in a home care program, by David Littauer and Robert Hickok. *Phys. Therapy Rev.* Apr., 1959. 39:4:217-226.

Home care programs for long-term illness, a new resource used in recent years to supplement or complement care in the hospital, have opened up new areas of interest for physical therapists. An analysis of services provided home-care patients by the physical therapist in a program organized and administered by the Jewish Hospital of St. Louis is presented. During the first five years' operation of the program 294 patients were accepted for treatment. Data on referrals, their source and acceptance, age and sex of patients treated on home care, length of care and type of services rendered, type of equipment used in the home, and physical therapy procedures utilized are given. Fees for service and compensation of the therapist are mentioned briefly. A detailed case history illustrates the soundness of using home treatment for selected cases.

HOMEBOUND—PROGRAMS

See 573.

HOSPITALS

561. Abdellah, Faye G. *(Div. of Nursing Resources, U.S. Public Health Service, Washington 25, D.C.)*

Progressive patient care, by Faye G. Abdellah and E. Josephine Strachan. *Am. J. Nursing.* May, 1959. 59:5: 649-655.

A progress report on a new approach to patient care in the hospital, based on extensive research being conducted by the U.S. Public Health Service. Progressive patient care (PPC) involves the organization of facilities, services, and staff around the medical and nursing needs of the patient. Such a program, embodying four of the five elements of progressive patient care, has been in operation since 1957 at the Manchester Memorial Hospital, Manchester, Conn. Organization and administration of units for special care, intermediate care, continuation care, and self service are discussed. Problems still to be solved and implications of the approach to nursing care for nursing education are being studied by the U.S. Public Health Service's research team. Findings of the Manchester pilot study and survey findings of other hospitals operating progressive patient care programs will eventually be incorporated in a guidebook planned for use by hospitals and health centers in developing similar programs. Guide materials, including architectural drawings and equipment lists, are available upon request from the Division of Hospital and Medical Facilities, U.S. Public Health Service, Washington 25, D.C.

562. Berkeley, J. *(1273 Ouelette Ave., Windsor, Ont., Canada)*

Physical medicine and rehabilitation in a general hospital. *Canad. J. Public Health.* Dec., 1958. 49:12: 499-502.

An increasing trend toward the development of rehabilitation services in the general hospital poses problems for administrators and hospital medical staffs. The broader objectives of rehabilitation demand changes in the concept of services, calling for the creation of a physical medicine department containing sections for both physical and occupational therapy. Social and vocational rehabilitation services can be obtained through cooperation with community agencies providing such services. Care of convalescents and patients with chronic disease should be transferred to another center or to a convalescent wing of the general hospital. The team approach is necessary for the integration of medical, social, and vocational aspects of rehabilitation. Suggestions for the planning and administration of rehabilitation services in the community are offered.

See also 589; 603.

LATERALITY

563. Edelstein, Gerald *(Dept. of Rehab. Medicine, Albert Einstein Coll. of Medicine, Eastchester Rd. at Morris Park Ave., New York 61, N.Y.)*

Correlation of handedness and degree of joint contracture in bilateral muscle and joint diseases. *Am. J. Phys. Med.* Apr., 1959. 38:2:45-47.

Presents findings of a study of the relationship of degree of muscular activity and extent of joint contracture in patients with bilateral disability (muscular dystrophy). Since it is known that the dominant side of the body is more active and also that muscular disuse is one of the major factors contributing to the development of joint contracture, the range of motion of dominant and non-dominant sides was tested for the shoulder, forearm, and hip joints. The dominant side of the body showed a significantly decreased amount of contracture in these joints. It is suggested that increased activity should reduce contractures already formed and possibly aid in the prevention of such contractures. Since all patients studied had received varying amounts of physical therapy, it is expected that an even greater difference might be found in patients who had not received therapy. A study of the quantitative effects of physical therapy on the reduction of contractures would be of value in assessing treatment technics.

LIBRARY SERVICE

564. Phinney, Eleanor

Trends in library services to the aging. *A.L.A. Bul.* June, 1959. 53:6:534-535, 539.

Reports further findings of a continuing study begun in 1957 by the U.S. Office of Education to evaluate services and activities of public libraries that are designed to meet the needs of an aging population. The author is executive secretary of the Adult Services Division of the American Library Association and was responsible for collecting data. A lengthy and detailed questionnaire was sent to 200 libraries in all parts of the United States; replies were received from 140, indicating an awareness of the need for attention to the special problems of older persons in the community. Sixty percent of the libraries responding reported their libraries were planned for ease of access; 42 percent noted that rules were relaxed for those who could not come regularly. Special shelving of material of interest to older people or of materials in larger print were reported by 35 percent and 30 percent, respectively. Programs planned for older people as a group utilized a variety of activities and media. Libraries in general appear to work closely with community agencies and organizations serving the aging.

565. Stone, Winifred *(Natl. Comm. on the Aging, 345 E. 46th St., New York 17, N.Y.)*

Library service to the aging. *Library J.* June 1, 1959. 84:11:1758-1761.

Librarians interested in providing services for an aging population will find here information on work of the National Committee on Aging, a central resource for organizations and persons working in the field. Libraries are recognizing their responsibilities and initiating special programs in the community to meet the needs of this particular age group. The Library of the National Committee on Aging serves as a clearinghouse for information on the types of material public libraries will find available and valuable in promoting services for the aging.

MENTAL DEFECTIVES

566. Krishef, Curtis H. *(Natl. Assn. for Retarded Children, 99 University Pl., New York, N.Y.)*

A study of factors related to rating post-institutional adjustment, by Curtis H. Krishef, Maynard C. Reynolds, and Clayton L. Stunkard. *Minn. Welfare.* Spring, 1959. 11:1:5-15, 46.

In same issue: Job placement of the mentally deficient, Harold F. Mickelson. p. 16-20, 33.

A study of the post-institutional adjustment of persons in the so-called educable range who had been discharged from a state institution for the mentally deficient. Information was obtained through two questionnaire forms, one for institutionalized wards and one for those currently living in the community. All persons studied had been discharged from the state institution an average of seven years. Data presented in tabular form cover characteristics of dischargees and their follow-up status, variables possibly affecting adjustment, and factors most influentual in total adjustment. It would appear that social workers responsible for rating adjustment relied mainly upon the individual retardate's ability to relate to others when judging quality of adjustment. They appeared to give little or no weight to the retardate's capacity to be economically self-sufficient.

Mr. Mickelson *(Mower Co. Welfare Board, Austin, Minn.)* discusses the responsibilities—legal and moral—of the county welfare board in vocational placement of mentally defective individuals discharged from state institutions.

MENTAL DEFECTIVES—DIAGNOSIS

See 545; 583.

MENTAL DEFECTIVES—PARENT EDUCATION

567. Minnesota. Department of Public Welfare

Now they are grown; help for parents of teenage and young adult trainable retarded children. St. Paul, The Dept., 1959. 60 p.

The fourth in a series of booklets published by the Minnesota Department of Welfare's Conference Committee on Mental Deficiency to aid parents who plan to care for their older retarded children at home. Advice is given on how parents can develop acceptance of the retarded person by family and neighbors, how the retarded can be trained to become a contributing and disciplined family member, and how parents can aid in the development of satisfactory interests and friendships for the retarded. Methods for handling behavior problems and socially unacceptable habits are illustrated with actual examples provided by parents. A realistic discussion of the specific problem of employment for the retarded and the question of marriage is presented. Earlier booklets in the series were *Teach Me*, published in 1946, *You Are Not Alone* (1954), and *Looking Ahead* (1956), all planned to help parents adjust to the knowledge of their child's mental retardation and to help them plan for the child's care through use of community resources. *Teach Me* contains suggestions for the care and management of the young trainable mentally retarded child.

Available from Minnesota Dept. of Public Welfare, 117 University Ave., St. Paul, Minn., or the Minnesota Assn. for Retarded Children, 2742 Hennepin Ave., Minneapolis, Minn.

MENTAL DEFECTIVES—PROGRAMS

See p. 201.

MENTAL DISEASE—EMPLOYMENT

568. Irvine, Lillian S. *(State Dept. of Mental Health, 15 Ashburton Pl., Boston 8, Mass.)*

Rehabilitation and placement of the emotionally handicapped, by Lillian S. Irvine, Louis M. Tracy, and Isaac F. Fine. *Employment Sec. Rev.* May, 1959. 26:5:17-19.

A statewide cooperative plan involving the Division of Employment Security, the Department of Mental Health, and the Rehabilitation Commission in Massachusetts seeks to augment psychiatric rehabilitation services provided by the hospital with vocational rehabilitation and placement services to move the mental patient into the community and into employment in competitive industry. Organization and administration of services are explained. Analysis of experience within the program will eventually result in refinement and development of technics to evaluate readiness for employment, selective placement, and orientation of former mental patients.

MULTIPLE HANDICAPS

See 532; 541; 553.

MULTIPLE SCLEROSIS

569. Health News, N.Y. State Dept. of Health. May, 1959. 36:5.

Contents: For better rehabilitation, Herman S. Hilleboe. p. 3.—Multiple sclerosis, Morton Marks. p. 4-14.—Multiple sclerosis; an enigma, Wardner D. Ayer. p. 15-17.

Dr. Marks reviews the problems in regard to the disease, some of the newer research findings, clinical features that vary considerably, and what is possible in the way of supportive and symptomatic treatment. He stresses that no simple single regimen of treatment is applicable to all patients with multiple sclerosis; the rehabilitation program must be highly individualized for each patient. Dr. Ayer discusses the disease from the neurologist's point of view and recommends some specific measures in treatment that appear to help maintain the patient in a functionally active state.

MULTIPLE SCLEROSIS—PHYSICAL THERAPY

570. Boynton, Ben L. *(303 E. Chicago Ave., Chicago 11, Ill.)*

Observations on the effects of cool baths for patients with multiple sclerosis, by Ben L. Boynton, P. M. Garramone, and Josephine T. Buca. *Phys. Therapy Rev.* May, 1959. 39:5:297-299.

Ten patients with multiple sclerosis, most of whom displayed severe neurological damage, were selected to receive a form of therapy discussed in an article appearing in *Physical Therapy Review,* May, 1958. Patients were immersed for 10 minutes in the Hubbard tank in water at a temperature of 80 degrees F. (27 degrees C.). Treatment has appeared to be of material benefit in improved neuromuscular coordination. All patients reported a feeling of relaxation with less muscle spasm and increased ease in the sitting or standing positions. It is believed that the use of such treatment early in the course of the disease may prolong the period of functional activity. The technic is simple enough for home use and, in the authors' experience, can be administered without ill effects.

MUSCULAR DYSTROPHY—PHYSICAL THERAPY

See 563.

NEUROLOGY

See 554.

NURSING

571. Ulrich, Elizabeth A. *(V.A. Hosp., 2650 Wisconsin Ave., N.W., Washington 7, D.C.)*

Rehabilitation nursing in a specialty hospital (tuberculosis). *Military Med.* May, 1959. 124:5:363-366.

Comprehensive nursing care, the teaching of hygienic habits for prevention and control of tuberculosis, and the coordination of the many hospital services to assist the patient in his recovery are the responsibility of the nurse in the tuberculosis hospital. Because the nurse is in constant contact with the patient, she is more aware of personal and economic problems that may interfere with the rehabilitation process. Role of the nurse in the admission procedures, in the day-to-day treatment, and in preparing the patient for return to the community is discussed.

See also 531.

NURSING—PERSONNEL

572. Branson, Helen Kitchen

The physically handicapped nurse. *Hosp. Management.* June, 1959. 87:6:102, 140, 144, 146.

Paraplegic, deaf, and blind nurses, those with orthopedic handicaps, and even the nurse with controlled epilepsy are finding employment in their field of work. Cooperative arrangements and adaptations in assigned duties allow the handicapped to make an adequate contribution in the professional or nonprofessional branches of nursing. The article discusses mainly those who had received their training or experience before becoming handicapped. However, some schools will accept for training those whose handicaps are not observable to the patient. Vocational rehabilitation agencies provide selected clients such training when known shortages of personnel offer opportunity for employment.

NUTRITION

573. Williams, Izola F. *(Ohio Dept. of Health, Columbus, Ohio)*

Home-delivered meals for the aged and handicapped, by Izola F. Williams and Charlotte E. Smith. *J. Am. Dietetic Assn.* Feb., 1959. 35:2:146-149.

In same issue: Feeding elderly people in their homes, C. Elizabeth Henry. p. 149-151.

The provision of adequate, palatable meals for the temporarily or permanently handicapped and for older persons with chronic illness can be both a therapeutic and a preventive health measure. The idea of "Meals on Wheels" originated in England in 1939 and was first introduced in the United States in 1954 by Philadelphia. Columbus, Ohio, has had such a program in effect for several years; the authors describe the organization of the project, eventually chartered by the state as a nonprofit organization. Methods of operation, policies in regard to eligibility, referral, and payments by recipients,

financing of the project, actual costs of operation, and problems necessitating changes in procedure are discussed. Data from an evaluation survey on the attitude of recipients, beneficial results of the service, and physical characteristics of the recipients are included.

For a digest of the second article, see #538 this issue of *Rehab. Lit.*

OCCUPATIONAL THERAPY

574. Rehabilitaton. Apr.-June, 1959. No. 29.

Entire issue devoted to the subject.

Contents: Introduction, Lord Amulree.—Training for occupational therapy, E. M. MacDonald.—The contribution of occupational therapy to the rehabilitation of patients with physical illness, injury, or permanent disability, Griselda MacCaul.—The place of the occupational therapist in the geriatric unit, Marjory W. Warren and Kathleen E. Vinden.—Domiciliary occupational therapy, Betty H. Rostance.—Assessment of work capacity in an occupational therapy department, James G. Sommerville.—Occupational therapy and the rehabilitation of psychiatric patients, Lynette M. Barrett.—Present and future trends of occupational therapy in Scotland, with emphasis on the treatment of severely handicapped adults in the Cerebral Palsy Unit, Edinburgh, Jean Waterston and Jane Errington.

OLD AGE—PROGRAMS

See 536; 538; 564; 565; 573; 604.

ORTHOPEDICS

575. Capener, Norman *(Princess Elizabeth Orthopaedic Hosp., Exeter, England)*

British orthopaedics. *Lancet.* May 9, 1959. 7080: 951-953.

A British orthopedic surgeon recounts the early history of his specialty in Great Britain and its role in the development of the rehabilitation concept. He points out particular problems currently engaging the attention of orthopedic surgeons and makes recommendations for improving services to crippled children, amputees, those disabled in military service, those suffering accidental injury, and patients with rheumatoid arthritis and degenerative conditions. Wider cooperation between all branches of medicine and surgery is urged. The article was presented as the presidential address at the 1959 meeting of the British Orthopaedic Association.

PARALYSIS AGITANS

576. Nielsen, J. M. *(727 W. 7th St., Los Angeles 17, Calif.)*

Parkinson's disease. *Bul.,* Los Angeles Neurological Soc. Dec., 1958. 23:4:171-177.

A discussion of the symptoms of genuine paralysis agitans as contrasted with "parkinsonian syndromes," which are groups of individual symptoms resembling paralysis agitans but are of different etiology and with a different course. Loss of associated movements, effect of the disease on posture, characteristics of the rigidity of muscles, the typical tremor of paralysis agitans, disturbances in timing, emotional symptoms, and disturbances of vegetative functions in the disease are discussed. Etiology of the disease is unknown. The author discusses briefly conditions simulating paralysis agitans and the medical, psychological, and surgical aspects of treatment of paralysis agitans for which there is no known cure.

PARALYSIS AGITANS—MEDICAL TREATMENT

577. Doshay, Lewis J. *(710 W. 168th St., New York 32, N.Y.)*

Treatment of paralysis agitans with chlorphenoxamine hydrochloride, by Lewis J. Doshay and Kate Constable. *J. Am. Med. Assn.* May 2, 1959. 170:1:37-41.

A new drug, used for several years in Germany, was administered to 25 specially selected patients with paralysis agitans in an attempt to establish its effects, side reactions, and range of therapeutic dosage. The drug was subsequently administered to 136 patients who had been treated unsuccessfully with other drugs. Data from the studies indicate that the drug is free from toxic effects and has positive value in treatment of the disease, being especially effective against rigidity, akinesia, fatigue, depression, and weakness but less against tremor. Increased tolerance is comparatively rare. The method of administration and experience with dosage are discussed. The drug is of little benefit in non-Parkinsonian extrapyramidal diseases. An additional advantage is that it may be used alone or in combination with drugs in current usage for paralysis agitans.

PARALYSIS AGITANS—STATISTICS

578. DeJong, David *(Queen Mary Veterans Hosp., 4565 Queen Mary Rd., Montreal, Canada)*

Parkinson's disease; morbidity and mortality figures. *Med. Serv. J., Canada.* Nov., 1958. 14:10:695-706.

As part of the Parkinson's Project being conducted at Queen Mary Veterans Hospital, Montreal under a grant from the Department of Veterans Affairs, a study of the problems incident to determining morbidity and mortality data has been made. The difficulties of establishing accurate figures on incidence of the disease are discussed. In Canada statistics are lacking since regular records are kept only for communicable diseases, a situation also existing in the United States and other countries. Data from the Canadian Sickness Survey (1950-51) and from other government sources are given. A summary of the various findings is not possible, however, since there is no basis for comparison between the groups of figures quoted. An estimate for morbidity incidence in the population at large is set at a possible 0.1 percent; in the older age group an incidence of 1.0 percent or more is not viewed as improbable. Mortality statistics for Parkinson's disease are given by age group for the years 1931 through 1956. The true mortality rate will become available only as the disease is more clearly defined, more widely understood, and more carefully diagnosed in terms of causes of death.

PARAPLEGIA—GREAT BRITAIN

579. Coal Industry Social Welfare Organization (Gt. Brit.) **Disablement Advisory Committee**

Report of the Survey of Paraplegic Mineworkers, conducted under the direction of Alan G. Hardy . . . and E. O. Beer. London, The Organization, 1957. 82 p. tabs.

Data from a survey of paraplegic mineworkers in Scotland and England living under home conditions during 1954 and 1955 revealed the extent of their social needs and the effect of degree of disability on these needs. Of the 497 men interviewed, 253 had complete paraplegia. Needs of the individual varied not only with degree of disability but also according to his circumstances and personality. After analysis of the data, it was recommended that the most pressing needs for improvement in transportation, housing, and statutory benefits should be reviewed. A coordinated plan for rehabilitation of paraplegics would achieve more successful results; a medical social service is necessary to help the paraplegic and his family with physical and psychological problems of adjustment. Special welfare schemes for paraplegic mineworkers are discussed. The report suggests that those who received treatment in spinal injury rehabilitation centers were more able to adjust to the physical and social problems caused by paraplegia.

The report is given editorial review in the *Brit. Med. J.* Feb. 28, 1959, p. 567.

Available from the Coal Industry Social Welfare Organization, 5 Hobart Place, London, S.W. 1, England.

PARTIALLY SIGHTED—BIBLIOGRAPHY

580. Galisdorfer, Lorraine

Educational reading guide for the partially seeing. Buffalo, N.Y., Foster and Stewart Publ. Corp., 1951. 83 p. (*2d. ed.*)

Together with: Supplement A (1951-1953); Supplement C (1953-1955); and Supplement D (1955-1959).

First published in 1950 and revised in 1951, this publication has been brought up to date with supplements covering the intervening years to 1959. It lists reading material available in large type for use in sight conservation classes or for children with visual impairment who are in regular classrooms. Each entry includes the usual bibliographic information, as well as price and publisher, size of type, and brief annotation describing contents. Books are listed by category according to age, type of publication, or curriculum area. The author index and list of publishers' addresses contribute to the usefulness of the listing.

The guide, including the three supplements, is available from Henry Stewart, Publishers, 210 Ellicott St., Buffalo, N.Y., at $3.00, postpaid.

PARTIALLY SIGHTED—SPECIAL EDUCATION

See 537.

PHYSICAL EDUCATION

581. Haliczer, S. L. *(658 E. State St., Jacksonville, Ill.)*

Physical education tests for boys. *Internatl. J. Educ. of the Blind.* May, 1959. 8:4:129-133.

A comparison of results attained by visually handicapped boys in common physical education activities with national averages achieved by sighted students. Over two-thirds of the students tested at the Illinois Braille and Sight-Saving School, Jacksonville, compared favorably with the national averages. The two tests used in determining achievement in physical education activities are described; the scoring system is explained. The tests provide suitable physical education activities that interest students and an adequate program for meeting students' physical needs.

PHYSICAL EDUCATION—PERSONNEL

582. Fleer, Paul F. *(Crotched Mt. Rehab. Center, Peterborough, N.H.)*

A survey of the educational and professional backgrounds of active members of the Association for Physical and Mental Rehabilitation. *J. Assn. Phys. and Mental Rehab.* Mar.-Apr., 1959. 13:2:44-46, 63.

A summary of the findings of a survey of the active membership of the Association for Physical and Mental Rehabilitation, made to determine their current educational and professional backgrounds. Over 60 percent of active members provided the information desired. A comparison of the data with findings of a similar survey conducted in 1952 showed a 7.8 percent increase in those who have worked on the graduate level, a 2.3 percent increase in degrees conferred, an 8.6 percent decrease in those completing degree requirements, and a 14 percent decrease in those not meeting degree requirements. On the graduate level, there was a 19.3 percent decrease in those majoring in physical education and health, with a concomitant increase in majors in rehabilitation and other areas. Almost one in every 10 persons who replied to the questionnaire had worked on the doctoral level. An estimated 90 percent of those replying had participated in additional or specialized training in rehabilitation. Nearly 90 percent affirmed they were certified corrective therapists; others indicated they were planning to take the examination or, having taken it, had not yet been informed of results. Membership in other professional organizations was widespread.

PHYSICAL EFFICIENCY

583. Howe, Clifford E. *(Coll. of Educaton, Univ. of Illinois, Urbana, Ill.)*

A comparison of motor skills of mentally retarded and normal children. *Exceptional Children.* Apr., 1959. 25:8: 352-354.

An article based on the author's doctoral dissertation completed in 1958 at the University of Iowa. A study was made of mentally retarded children in public schools as compared with normal children, in regard to correlation between motor performance and intelligence. Only those mentally retarded children with no evidence of brain damage were chosen for study. Eleven motor tasks, easy to demonstrate and simple to perform, were administered individually. For boys, the normal group was significantly superior to the retarded group on each of the 11 tasks; the normal group of girls showed differences significant at the five percent level for all but two of the tasks. The majority of the retarded were unable to balance on one foot, a task relatively easy for normal children. Results of this particular task are puzzling since none of the retarded was judged to have brain damage. It raises some speculations in regard to the exogenous-endogenous issue. It is suggested that a structured program of physical education might be valuable in the curriculum for the retarded.

PHYSICAL THERAPY

584. Kruse, Robert D. *(Frank E. Bunts Educational Inst., 2020 E. 93rd St., Cleveland 6, Ohio)*

Current trends and practices in physical therapy. *Phys. Therapy Rev.* May, 1959. 39:5:304-311.

Survey findings in regard to job responsibilities and activities of physical therapists. Data were obtained by questionnaires sent to active members of the American Physical Therapy Association of whom 3,518 responded. Evaluation of the data should indicate current trends in the practice of physical therapy and provide information of value to schools of physical therapy in curriculum planning and in the assessment of inservice training programs. Statistics on type of employment, job responsibilities, and the frequency of use of various modalities, procedures, and technics are tabulated.

POLIOMYELITIS

See 592.

PSYCHIATRY

585. Zane, Manuel D. *(15 E. 36th St., New York 16, N.Y.)*

Role of personality traits in rehabilitation problems. *Arch. Phys. Med. and Rehab.* May, 1959. 40:5:197-202.

Often in the rehabilitation process, effective motor-learning is adversely affected by the patient's characteristic way of reacting to stress. Personality traits developed as defenses against anxiety can inhibit the cerebral processes necessary for effective learning; defensive motor actions can oppose or interfere with the motor action being learned. Characteristic reactions of the patient can adversely affect the therapist in her work. The psychiatrist serving as a consultant in the rehabilitation program can help the therapist to understand the patient's problems in learning and point out ways of reducing stressful aspects of the learning situation. Ten case reports are included to illustrate how personality traits block learning as well as the therapeutic methods of approaching the problem.

PSYCHOLOGICAL TESTS

586. Lange, Patricia *(Massachusetts Hosp. School for Crippled Children, Canton, Mass.)*

Frustration reactions of physically handicapped children. *Exceptional Children.* Apr., 1959. 25:8:355-357.

An equal number of children with congenital handicaps and children with acquired handicaps, within the age range of 5 to 21 years, were tested by means of the Rosenzweig Picture-Frustration Study to determine possible behavioral differences and frustration reactions. Previous studies have suggested that behavioral differences exist and that frustrations increase with age. No significant differences in the scores of congenitally handicapped children and those with handicaps acquired after birth were found; such differences may actually fail to exist or may lie in facets of personality or behavior in areas other than those considered in this study. Further research might investigate the influence of degree of disability on frustration reactions. Additional testing instruments such as the Children's Apperception Test might be used for further exploration of the reactions of children with congenital and acquired handicaps.

587. Monfraix, C.

Etude des perceptions manuelles chez l'enfant normal, (by) C. Monfraix, G. Tardieu, (and) C. Tardieu. *La Presse Medicale.* Apr. 18, 1959. 67:19:771-772.

A discussion of a test used to evaluate manual perception in the normal child, a nonverbal form of which can be used in testing cerebral palsied children. Gnostic disorders seen in the hemiplegic child are more difficult to diagnose when they are bilateral since little data on the development of such perception in the normal child have been available for comparison. The study of tactile perceptions (recognition of objects and of geometrical forms) in 218 normal children by the authors has provided information on the development of such ability in the child's evolution. Children of $2\frac{1}{2}$ years of age are able to recognize objects, but ability to recognize geometrical forms does not develop until later. The number of geometrical forms recognized increases with age and constitutes a test that allows evaluation of the child's "gnostic age." The test should not be used with children less than $3\frac{1}{2}$ years of age. With children beyond the age of $6\frac{1}{2}$ years, the test is not useful since it becomes too easy. Text of the article is in French, with English and Spanish résumés.

PSYCHOLOGY

588. Shontz, Franklin C. *(Highland View Hosp., Harvard Rd., Cleveland 22, Ohio)*

A psychobiological analysis of discomfort, pain, and death, by Franklin C. Shontz and Stephen L. Fink. *J. Gen. Psych.* 1959. 60:275-287.

Although interest in the study of psychological reactions to discomfort and pain resulting from physical illness and handicap has increased in recent years, the authors have found no theory offered that promises inclusion of the many and varied forms of human illness and the wide range of responses made to these conditions. They present a "total structure" concept explaining human behavior in relation to physical discomfort, pain, and death. Four specific orientations to these particular phenomena are used to explain masochism, sadomasochism, ritual self-mutilation, suicides, heroism, martyrdom, symptom-denial, ritualism, compulsive overproduction, hypochondriasis, hysteria, accident-proneness, and mature creativity. The concept, because of its emphasis upon the "relationships" that characterize the individual rather than upon classic organism-environment distinctions, offers a more logical explanation of phenomena that have not yielded previously to consistent theoretical analysis.

See also 547.

READING

See 533.

RECREATION

See 604.

REHABILITATION

589. Willard, Harold N. *(Thayer Hosp. Associates, North St., Waterville, Me.)*

Rehabilitation on a general medical ward, by Harold

N. Willard (and others). *N. Eng. J. Med.* Dec. 4, 1958. 259:23:1112-1114.

A follow-up study of all male patients admitted to a general medical ward of a teaching hospital during one year was made two years after their discharge from the hospital. Only those between the ages of 20 and 60 were included in the study; return to work was used as one criterion of the success of hospital treatment. Evaluation was made to determine whether classic medical care had been adequate or if additional rehabilitation services were needed. Of the 96 patients available for study 33 were well and employed, 42 had shown no improvement, and 21 were definitely worse. Rehabilitative services for the last group were judged to offer no possibility of benefit. The group who were unimproved at time of follow-up study appeared to offer the best opportunity for substantial benefit through long-term rehabilitation programs, with attention to the patient's environment and residual assets. If this group could be identified in the hospital, optimal long-term results could be achieved.

REHABILITATION—GREAT BRITAIN

See 575.

REHABILITATION—U.S.S.R.

590. Tizard, J. *(Institute of Psychiatry, Maudsley Hosp., London, Eng.)*

Children in the U.S.S.R.; work on mental and physical handicaps. *World Mental Health.* Feb., 1959. 11: 1:16-31.

Reprinted from: *Lancet.* Dec. 20, 1958. 7060:1325-1330.

In his capacity as a consultant to the World Health Organization, the author spent three weeks in Russia observing mental health work and care provided for handicapped children. Educational provisions, institutional facilities, medical and psychiatric care, provisions for children in special categories (the deaf and the blind), qualifications for teachers and other personnel, salary structure, and research on handicaps are discussed, as well as experimental technics and educational aids. Psychological research in Russia is well supported and of high quality and originality. In the author's opinion the greatest weakness in the research he observed lay in the area of experimental design and statistics.

REHABILITATION—EQUIPMENT

See 556.

REHABILITATION—PERSONNEL

See 546.

REHABILITATION—SURVEYS—NEW YORK

591. Mosher, William E. *(Deputy Health Commissioner, Erie County, City Hall, Buffalo 2, N.Y.)*

An evaluation of young adults with severe neuromuscular disorders to determine community needs for vocational rehabilitation services. *Am J. Public Health.* May, 1959. 49:5:622-633.

Findings of a survey to determine the needs of moderately or severely handicapped persons between the ages of 16 and 30 who had been discharged from treatment centers and resided in Buffalo or Erie County, N.Y., revealed that facilities in the community were not adequate to meet their vocational rehabilitation needs. The study group consisted of 30 poliomyelitis patients and 117 with cerebral palsy. A detailed analysis of the data obtained is included and covers physical status (based on living abilities and medical disability status), mental status, educational attainments, present activity in the home and community, and possible benefit from community organized programs. The author's recommendation for a solution to the problem was a complete rehabilitation center for the community to meet the needs of all groups of the disabled. Additional disease-centered facilities were not deemed desirable for the purpose.

REHABILITATION CENTERS—ADMINISTRATION

See p. 195.

RESPIRATION

592. Loeser, William D. *(Youngstown Hosp. Assn., South Side Unit, Youngstown, Ohio)*

Oral intermittent positive pressure breathing (OIPPB) in poliomyelitis, by William D. Loeser and Marian F. Kerr. *Arch. Phys. Med. and Rehab.* May, 1959. 40:5: 203-209.

Describes a new method of artificial ventilation in which filtered air is intermittently pumped to the patient's mouth using a hose and pipestem mouthpiece. Advantages of the method are maximal freedom from encumbrances for the patient, improved accessibility for nursing care, and self-selection of tidal volume by the patient. In addition, it allows the patient to stand and walk and helps to maintain mobility of the rib cage. Advantages of OIPPB have been demonstrated in 34 patients with poliomyelitis who required respiratory assistance. Two case reports are included. Equipment used is described and limitations in use of the method are discussed.

SOCIAL SERVICE (MEDICAL)

593. Bernstein, Herbert *(V.A. Hosp., Bronx 68, N.Y.)*

Social aspects in the rehabilitation of the physically handicapped. *J. Assn. Phys. and Mental Rehab.* Mar.-Apr., 1959. 13:2:52-55, 64.

The crucial influence of the family unit, the community, and cultural patterns on the etiology and treatment of individual dysfunction is currently recognized. In the rehabilitation of the physically and psychologically handicapped, the approach should be based on the handicapped person's own situation within the context of family life. The author discusses the assessment, planning, and preventive social aspects of rehabilitation from the viewpoint of the social worker.

SPECIAL EDUCATION—FINLAND

594. Taylor, Wallace W. *(N.Y. Univ. College for Teachers, Albany, N.Y.)*

The education of physically handicapped children in

Finland, by Wallace W. and Isabelle Wagner Taylor. *Exceptional Children.* Apr., 1959. 25:8:358-367.

The first of a series of articles on education of the physically handicapped in foreign countries. Information was gathered in a survey made under the auspices of the International Society for the Welfare of Cripples and the International Union for Child Welfare with financial support from the World Rehabilitation Fund, the Association for the Aid of Crippled Children, the National Foundation, and the Easter Seal Research Foundation of the National Society for Crippled Children and Adults. Special geographic, economic, and social features of Finland influence educational provisions. Data on types of handicapping conditions found among school children are included. Special education provisions, programs for hospitalized and homebound, recreational and vocational services, and teacher training are discussed.

SPECIAL EDUCATION—NEBRASKA

595. Nebraska. State Department of Education *(State Capitol, Lincoln 9, Neb.)*

Special education; Nebraska's public school services for handicapped children, prepared by Vernon E. Hungate, Galen W. Dodge, and Dorothy E. Holland. Lincoln, The Dept., 1959. 39 p. forms.

Information prepared for boards of education, administrators, and teachers in Nebraska, covering legislative provisions for special education programs and the specific procedures for establishing various types of programs. Aims, policies, and regulations in regard to special education in the state are defined; specific procedures for the organization of programs for the educable mentally handicapped, the hard of hearing, the homebound, the orthopedically handicapped, the partially sighted, and those requiring speech and hearing therapy are described. Contains a six-page bibliography of selected references useful to parents and educators. Referral forms are included.

SPECIAL EDUCATION—LEGISLATION

596. U.S. Office of Education

State school legislation, 1957, by Arch K. Steiner. Washington, D.C., Govt. Print Off., 1959. 189 p. *(Bul. 1959, no. 10)*

A brief resume of state laws of significance to education enacted by the states during 1957 and pertaining to such aspects as administration and organization, financial support, higher education, personnel, school building and construction, special education, and services to students. Includes information on all states with the exception of Virginia and Kentucky where the state legislatures did not meet during 1957. No attempt was made to evaluate the educational significance of each act.

Available from U.S. Superintendent of Documents, Washington 25, D.C., at 70¢ a copy.

SPEECH CORRECTION

597. Goda, Sidney *(Edward R. Johnstone Training and Research Center, Bordentown, N.J.)*

Speech stimulation practices among mothers of preschool children, by Sidney Goda and Kay Smith. *J. Speech and Hear. Disorders.* May, 1959. 24:2:150-153.

It is recognized that an inadequate amount of speech stimulation is detrimental to speech development, but there appears to be great individual variation in the amount of speech stimulation required by different children. The authors interviewed 75 mothers of preschool children between the ages of two and five to determine the amount of time spent by the children in each of six areas of speech stimulation (conversation, outings, being read to, listening to the radio, watching television, and playing with other members of the family). Total group habits, differences among age groups in time spent in each activity, and parental ratings of the importance of each of the six stimulation procedures are discussed. The study suggests certain clinical areas for exploration by speech therapists in interviewing parents. The kind of speech stimulation received by the child may be of significance in determining the etiology of the child's speech problem.

See also 530.

SPEECH CORRECTION—LEGISLATION

598. Irwin, Ruth Beckey *(Derby Hall, Ohio State Univ., Columbus, Ohio)*

Speech therapy in the public schools; state legislation and certification. *J. Speech and Hear. Disorders.* May, 1959. 24:2:127-143.

The rapid growth of speech therapy in public schools during the past 15 years necessitated a current review of legislative and certification provisions. The author has compiled a state-by-state analysis of laws and certification requirements; pertinent excerpts from state laws are included with the plan of subsidy provided in each case. For the most part laws are permissive but wording is broad enough to be interpreted as including the speech handicapped even where the "speech defective" is not actually named as falling within the sphere of special education provisions. Such laws are now in force in 39 states. Certification plans in approximately 32 states would appear to coincide with requirements set up in the Basic Speech Certificate of the American Speech and Hearing Association. This is evidence of definite growth since 1955 when the author reported 15 states with certification requirements approaching those of the lowest grade of certification in the Association. The public school therapist is usually required to take professional courses in education in addition to specified courses in basic science and specialized speech and hearing courses.

TUBERCULOSIS—NURSING CARE

See 571.

TUBERCULOSIS—RESEARCH

See 534.

TUBERCULOSIS—SPECIAL EDUCATION

599. Robert, J.

Le handicap scolaire de l'enfant tuberculeux pulmonaire. *Courrier.* Mar., 1959. 9:3:145-153.

Childhood tuberculosis in France remains a problem requiring nearly 15,000 beds in hospitals, sanitaria, and institutions for preventive care. The educational aspects are discussed in this paper; 200 French children, 100 Belgian children, and 100 French-speaking Swiss children

between the ages of 10 and 15 were evaluated. Findings showed that it was unusual to see no school retardation in children below the age of 13; the great majority of those with normal intelligence (IQ between 90 and 110) were educationally retarded in proportion to the extent of immobilization by the disease. In children over 13 years of age, school achievement was most often related to IQ since these children had attended school normally up to that time. The author suggests as a solution the provision of "post-cure" centers, residential schools where medical services would be available and children could complete their convalescence in one or two years. School classes on a half-time basis would permit these children to make up the losses occasioned by illness.

VOCATIONAL GUIDANCE

600. Hecker, George J. *(400 First Ave., New York 10, N.Y.)*

Therapeutic elements in work evaluation. *J. Rehab.* Mar.-Apr., 1959. 25:2:21-22, 44.

From experience in the Cerebral Palsy Work Evaluation Project at the Institute for the Crippled and Disabled, New York City, the writer concludes that work evaluation carried on in the group setting has therapeutic benefits. Poor work habits and problems of personal adjustment need to be remedied before the client is ready for employment. Positive growth and development in social relationships, work performance, and acceptance of disability are observed during the work evaluation program. Although the purpose of the program is not to offer therapy but to provide diagnostic insights on the individual's potential for employment, the project has been helpful in overcoming emotional conflicts, lack of self confidence, and hostility toward authority figures. The writer believes the technics are also adaptable to groups of the severely handicapped other than the cerebral palsied.

601. U. S. Office of Vocational Rehabilitation

Casework performance in vocational rehabilitation, compiled from proceedings of guidance, training, and placement workshops; edited by Bruce Thomason and Albert M. Barrett. Washington, D.C., Govt. Print. Off., 1959. 59 p. *(GTP bul. no. 1, Rehab. Serv. ser. no. 505, May, 1959)*

Material in the bulletin was developed by personnel of state vocational rehabilitation agencies and staff of the Office of Vocational Rehabilitation in workshops conducted during the past 12 years. Specific minimum goals of attainment in vocational rehabilitation counseling are set forth, defining the role of the counselor in case finding and referral, preliminary case evaluation, case work-up and diagnosis, program planning, and the provision of services. Administrative duties of the counselor and supervisor involved in casework are discussed. Suggestions for preparing the casework manual are given in the appendix. Rehabilitation personnel will find the summary of rehabilitation problems and practices in this area useful in evaluating the effectiveness of their programs.

Available from U.S. Superintendent of Documents, Washington 25, D.C., at 25¢ a copy.

VOLUNTARY HEALTH AGENCIES—PERSONNEL

602. American Public Health Association. Committee on Professional Education *(1790 Broadway, New York 19, N.Y.)*

Educational qualifications of executives of voluntary health organizations and health councils. *Am. J. Public Health.* May, 1959. 49:5:679-683.

A revision of an earlier report issued in 1945, it defines the functions of voluntary health agencies, the duties of their executives, and the knowledge, skills, and personal qualifications that executives should possess. Types of institutions best fitted to offer training in this field are discussed briefly.

VOLUNTEER WORKERS

603. Hospital volunteers; will they become friends or foes? *What's New.* Spring, 1959. 211:6-10.

Success of a volunteer program in the hospital depends upon a well-organized plan of services administered by a director of volunteers who is responsible for the recruitment, orientation, and placement of volunteers in jobs best suited to their capabilities. The best personnel procedures as practiced in industry should be adopted; accurate and comprehensive job descriptions should be developed by the volunteer director. The wide variety of services contributed by volunteers of all ages from the teenager to the retired person are discussed. Such services are valuable since they free the professional staff from extra duties and make more care available to patients.

604. Penney, John B. *(Recreation and Parks Dept., Concord, N.H.)*

Talent showcase for shutins. *Recreation.* May, 1959. 52:5:183.

Talented teenagers from junior high school and high school groups were recruited by the supervisor of women's and girl's activities in Concord's recreation department to bring entertainment to the elderly in old people's homes, nursing homes, rest homes, and wards of the state hospital. Organization of the program and its activities is discussed briefly.

New York State Health Activities Summarized

THE THIRD ANNUAL REPORT (1958) of the New York State Interdepartmental Health Resources Board (Room 1212, 11 N. Pearl St., Albany 7) includes summaries of state agency activities in the areas of health services for the aging, rehabilitation, and mental retardation and 1958 legislation authorizing a demonstration community center for mental retardates under the jurisdiction of the Board.

A Comment on Priorities in Brazil

"WE HAVE recently seen the first pioneering attempts to organise vocational rehabilitation of partly disabled workers (Decree No. 44770 of 3 November 1958, establishing an 'Executive Committee on Vocational Rehabilitation and Welfare' of the Industrial Workers' Pension Institution). It may be said in passing that from the economic point of view this problem does not deserve preferential treatment in Brazil."—*From "Manpower Problems in Brazil," by Estanislau Fischlowitz, Brazilian Ministry of Labor, Industry, and Commerce, in* International Labour Review, *April, 1959, p. 417.*

Amputee Clinic Teams Surveyed

PRIOR TO 1951, prosthetists and physicians rarely worked closely together to restore function to an amputee. This was changed as a result of steps taken to meet needs arising in World War II. Centers and programs were established by the Army, Navy, and Veterans Administration; the National Academy of Sciences conducted the Artificial Limb Research Program; the University of California at Los Angeles and New York University offered programs stressing the clinic-team concept. Several hundred clinic teams were formed throughout the United States, consisting of physicians, therapists, and prosthetists.

As a result of a request in August, 1958, from the Committee on Prosthetic Education and Information of the National Academy of Sciences to compile a roster of active clinic teams, the Committee on Advances in Prosthetics (Orthopedic Appliance and Limb Manufacturers) sent a questionnaire to 214 certified facilities. There was a 70 percent response. A list of 284 clinic teams was compiled, comprising the majority of those in the United States, Hawaii, and Puerto Rico. Data indicated that the clinic-team concept is for the most part well received. Criticisms of individual teams point up the need for self-analysis on the part of clinic teams so that service may be most efficient.

It was concluded that problems can be solved on a local level with the cooperation of team members and sometimes administrative officials. Two areas were found to need further study: *(1)* whether only new cases and those representing difficult problems should be taken up and *(2)* means to compensate prosthetists for time spent in clinic participation. The report presents a table of the number of prosthetic clinic teams per individual state or territory, a roster of teams arranged by state, and a listing of areas where, according to recommendations received, clinic teams should be established.—*From* Prosthetics Clinic Teams in the United States, *Report No. 1, 1959, prepared by A. Bennett Wilson, Jr., the Committee on Advances in Prosthetics, Orthopedic Appliances and Limb Manufacturers Association, 919 18th St., N. W., Washington, D.C.*

New Director Appointed At Benefit Shoe Foundation

ASSUMING THE DUTIES of the late Rev. Dale Dutton, Mr. Edward J. Duquette serves as the new Director of Human Relations of the Benefit Shoe Foundation, Inc., a nonprofit organization located at 861 Broad St., Providence 7, R.I. Mr. Duquette, now 72 years old, is a retired executive of a large adding machine corporation. The foundation sorts odd shoes received from about 30 shoe manufacturers and upon request sends them to persons such as amputees and those who have had poliomyelitis, who cannot use pairs of shoes as sold in stores. Leather, canvas, and waterproof footwear is available at below cost; a sorting charge is made to help defray expenses.

Capital Expenditures for Medical Reasons Are Sometimes Deductible

THE INTERNAL REVENUE Department has announced that it may allow the deduction of certain capital expenditures on income tax returns, providing property value is not increased. The $4,000 cost of installing, upon the advice of a doctor, an elevator in the home of a man with coronary insufficiency was ruled deductible recently by the U.S. District Court in western Oklahoma.

Exhibit on Handicapped Reader at Library Conference

AT THE ANNUAL conference of the American Library Association in Washington, D.C., June 21-27, a special exhibit of materials and equipment for use with the handicapped reader was featured. Reading aids and other equipment designed for the physically handicapped, blind, and partially sighted were displayed. The Adult Service Division and the Association of Hospital and Institution Libraries jointly sponsored an Institute on Library Service to an Aging Population (see #564, this issue of *Rehab. Lit.*)

Dr. Anne Carlsen Honored

THE EIGHTH ANNUAL President's Trophy for the "Handicapped American of the Year" was awarded on May 7 to Anne H. Carlsen, Ph. D., of Jamestown, N. Dak. The award was presented at the annual meeting of the President's Committee on Employment of the Physically Handicapped in Washington, D. C. Dr. Carlsen, who was born without feet or hands, has devoted her life to the rehabilitation and education of severely handicapped children and since 1950 has been Superintendent of the Crippled Children's School in Jamestown.

Louise W. Fraser Comments on Reaching the Brain-Damaged Child Through Music

"MUSIC IMPLIES order, and order is one thing lacking in the thinking of the brain damaged child. It is the one thing he needs the most, but the thing that he fights the hardest. In listening to and working through music, he is accepting order without resistance—the only way he will accept it. Even though help is aimed toward the individual child through music, he is being linked with others, and thus, individual distinction is eliminated. He is made to feel a sense of belonging to and of being accepted by his classmates. Because there is no feeling of hostility on the part of the child or the group when they are working together, each one is able to do, and be recognized for what he does, thus establishing a feeling of satisfaction in social acceptance."—*Louise W. Fraser, in* Music Therapy 1957; Seventh Book of Proceedings of the National Association for Music Therapy, *p. 109. 1958. 264 p. Allen Press, Lawrence, Kan. $5.20.*

Dr. Sydney Jacobs Comments on Rehabilitating the Tuberculous

"RESTORING a patient to full social and economic usefulness on recovery from tuberculosis is matched by today's counterpart: preventing his becoming useless. Traditionally, emphasis was placed on recreational therapy to help him pass the long hours of convalescence and recovery and to encourage him so that he would not give up the fight; subsequently emphasis was laid on building his morale and training him for suitable work so that he might not be forced into the type of poorly remunerative work which would foster his reactivation. More recently, we have been impressed by the need for total rehabilitation, i.e., psychologic guidance in addition to the earlier aims. The 'hard core' in tuberculosis is drawn from those at disadvantage physically, psychologically, and emotionally. Some of them are alcoholics, others narcotic addicts, and most of them are maladjusted or even overtly psychotic. Total rehabilitation is a much more demanding exercise than that of merely treating the pulmonary lesions, and yet it is tremendously needed today. It is quite possible that in the poorly understood field of physical-emotional relationships, social research will enable us to learn how these difficult cases may be more easily rehabilitated."—*From "Tuberculosis : A Community Problem," by Sydney Jacobs, M.D., in* J. La. State Med. Soc., *Apr., 1959, p. 125.*

Handicapped Persons Staff Texas Poison Control Center

THE FIRST manned by paralytics, the Gulf Coast Poison Control Center, of Houston, Tex., has a staff of three. A 3,000-card reference file on poisonous substances and their antidotes is maintained in the center. Specially built desks facilitate the work.

Educational Needs of Multihandicapped Require New Leadership

IN THE BOOK *Services to Blind Children in New York State* (Special Educ. and Rehab. monograph ser. 4, Syracuse University Press, Box 87, University Station, Syracuse 10, N.Y. $5.00), William M. Cruickshank and Matthew J. Trippe urge that a person be appointed at state level to lead in counseling local and residential school administrators on the education of multihandicapped children (both blind and nonblind handicapped). In New York this duty of follow-up after diagnosis and planning would be assumed by the State Education Department. The authors cite the example in Illinois, where an assistant to the Director of Education for Exceptional Children, State Department of Public Instruction, is solely responsible for the development of educational programs for such children. The authors state, "The education of multihandicapped children is truly a frontier of modern education and presents many problems which are yet to be solved. There are few educational problems that are more complex, or which require more immediate thought. . . ."

Mr. John Dolan Comments The Mentally Retarded Need Experience Opportunities

"DID YOU EVER SEE anyone learn to swim by reading a book? Learn to appreciate nature by sitting at home with the blinds drawn? Learn to be a carpenter by studying a manual? Did we learn to be friendly and make friends by sitting on a stool in the corner? Of course not!

I firmly believe many of the inabilities and unacceptable behaviourisms of retarded children could be improved, ameliorated, by wholesome, guided, stimulating, concrete experience opportunities."—W. John Dolan in Proceedings of the Workshop on Mental Retardation *conducted under the auspices of the Saskatoon Association for the Mentally Retarded at Saskatoon, Saskatchewan, Feb. 6 and 7, 1957. 45 p. Mimeo. Available from Mrs. J. B. Ellingham, 2521 Broadway, Saskatoon, Canada. $1.00.*

Doctoral Dissertation Reported

A REVIEW-DIGEST of the doctoral dissertation *The Effect of Disability on Self-Concept* by Irving Shelsky (Teachers College, Columbia University, 1957) appeared in the May, 1959, issue of *The New Outlook for the Blind*, pages 194-196, in the column "Research in Review" conducted by Herbert Rusalem, Ed. D.

Booklet Commemorates Exceptional Children's Week in Chicago

AN ILLUSTRATED BOOKLET *Children Exceptional: The Chicago Story of Achievement* describes the program of special education in the public and private schools of Chicago. The booklet is available from the Chicago Council for Exceptional Children, 2726 Argyle St., Chicago, at a cost of 50c.

Community Rehabilitation Center to Be Established in Philippines

A GRANT OF $105,000 was made by the General Foods Corporation for development of a community-sponsored, community-operated rehabilitation center in San Pablo, the Philippines, the first of its kind in the Far East. The center will serve outpatients and will at first have a staff of nine in addition to the medical director.

Los Angeles State College Offers M.S. in Rehabilitation Counseling

WITH FINANCIAL aid from the federal Office of Vocational Rehabilitation, Los Angeles State College will soon offer a Master of Science program in Rehabilitation Counseling. Courses will include the theory and practice of counseling, rehabilitation technics, personality and development, vocational psychology, and the study of disabilities. Major rehabilitation institutions in the Los Angeles metropolitan area will provide supervised professional experience. A number of stipends for full-time students will be provided by the Office of Vocational Rehabilitation. The stipend for the first year of graduate study is $1,800 and for the second year, $2,000. Interested persons should write to: Joseph Stubbins, Dept. of Guidance and Pupil Personnel Services, Los Angeles State College, Los Angeles 32, Calif.

OVR Has Projects in 30 States

FORTY-THREE DEMONSTRATION projects are currently being sponsored in 30 states by the Office of Vocational Rehabilitation. Special emphasis is being given to those projects providing improved methods of aiding the cerebral palsied, the mentally retarded, the disabled with emotional problems, and the near-blind.

Hospitalization of Children

"THE SALIENT POINTS in the new approach to the old problem of the treatment and welfare of children in and out of hospital can be summarized as follows:

"1. A system for the treatment of day patients should be devised for children who do not require prolonged in-patient treatment in hospital. . . .

"2. For those children who do require hospitalization for a shorter or longer period, the following considerations should always be kept in mind:

(a) Accommodation should be made available wherever possible for the mothers of infants and toddlers, preferably with the mother sleeping in the same room as her child.

(b) There should be unlimited facilities for relatives and friends to visit the children, except when it is inconvenient because of considerations of staff, treatment, etc.

(c) Evening visits should be encouraged.

(d) The actual duration of the treatment should be kept as short as possible.

"This new approach has, of course, its disadvantages as well as its advantages. To us it would seem, however, that the advantages outweigh the disadvantages. . . ." —*From* "Hospitalization of Children," *editorial in South African Medical Journal, Apr. 25, 1959, p. 353.*

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